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EXECUTIVE SUMMARY
Operational Review and Role Study
Workers' Rehabilitation Centre

Job # 1589

April 28, 1992

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1 Project Objectives

One of the 1991 goals of the Workers' Compensation Board was "to conduct a budget based review and role study for the Workers' Rehabilitation Centre. "

The Terms of Reference that accompanied the Request for Proposals for the study stated the following objectives:

1. To assess the Workers' Compensation Boards' present role of physical rehabilitation of injured workers.

2. To assess and analyze the Centre's services, and rehabilitation services to injured workers provided by other agencies, along the following criteria:

   Cost effectiveness
   Quality
   Availability
   Accessibility and Timeliness
   Effectiveness for preparing the injured worker for employment readiness

3. To determine whether alternatives to the present model of physical rehabilitation exist within the present Health Care Services in New Brunswick.

4. To recommend appropriate alternative models for the delivery of rehabilitation and treatment services for the injured worker population of New Brunswick.

5. To make recommendations with respect to the Workers' Rehabilitation Centre's present and future role in rehabilitation services for the population in general and injured workers in particular.

6. To assess the Workers' Rehabilitation Centre's efficiency in program management and coordination.

7. To assess the timeliness of completion of the physical rehabilitation process.

8. To conduct a Budget Base Review/Operational Audit of the Workers' Rehabilitation Centre to determine the appropriateness of present services and resources, both physical and financial.

2 Study Methodology

In order to address both the role study and operational review of the Workers' Rehabilitation Centre, our methodology incorporated a number of processes.

Information Gathering

The current injured workers' rehabilitation system was identified through information on the use of the Workers' Rehabilitation Centre and the use of general hospitals by injured workers. The tracking of rehabilitation services used and time intervals between them which were carried out on a sampling of claims for the Bathurst project, also provided perspectives. Provincial rehabilitation resources such as facilities, specialty physicians and other rehabilitation professionals were identified. The views of key informants including providers, injured workers and their representatives, Workers' Rehabilitation Centre staff, and Department of Health and Community Services representatives were obtained.

Alternatives for provision of injured workers' rehabilitation services were developed through interviews with key informants and discussion with providers of rehabilitation services to injured workers in Ontario, Saskatchewan, and Alberta.

The Operational Review of the Workers' Rehabilitation Centre

Information was obtained on the Centre as a whole and on each of its departments, collected in a consistent format. All departments were reviewed by a consultant with appropriate expertise. In addition a separate cost review of prosthetic and orthotic services was carried out.

Synthesis of Information

A workshop was held of all WRC management, the project Steering Committee, and the major consultants. The workshop was the means for synthesising the information, and forging a recommended role, structure and operations for the Centre.

Reporting

All consultants wrote individual reports and these were circulated to the project Steering Committee and Centre management, and discussed with both groups. For purposes of the final report, their findings and recommendations were consolidated.

Support

The project was supported by a Steering Committee.

3 Summary of Findings

3.1 The Workers' Compensation Board's Present Role of Physical Rehabilitation of Injured Workers

The mission of the New Brunswick Workers' Compensation Board (WCB) is:

> "To provide compensation benefits, medical, physical, and vocational rehabilitation services when required to all injured workers covered under the Workers' Compensation Act, in a fair, prompt, humane,and effective manner, through the administration of no fault insurance for the registered employer community."

This mission statement indicates a clear responsibility on the part of the Board for physical rehabilitation of injured workers.

Our initial information gathering, however, found ambivalence and perhaps even lack of commitment from key informants, not so much on the mandate itself as on how it should be performed.

The Board has owned and operated the present Workers' Rehabilitation Centre (WRC) since 1977. Some operations of the Centre are actually integrated with Board operations. Yet mutual appreciation of shared goals was difficult to detect. The WRC was not viewed as very effective and the Centre itself appeared to lack focus.

The Board also fulfils its responsibility for physical rehabilitation of injured workers by purchasing such services from public and private health care providers and more recently in the northern part of the province through the addition of a WCB physiotherapy clinic.

During our initial information gathering, it seemed as though almost all key informants were casting their thoughts towards the public health system as a means of providing rehabilitation services to injured workers. From the head office's perspective, if responsibility for physical rehabilitation were transferred to the public system, it would be in the hands of people who knew what they were doing and no longer be the millstone they perceived. From the Centre's perspective, integration might bring them into the mainstream, bring them a more interesting mix of clients, bring them recognition.

All of these perceptions were reinforced by the fact that the public health system, at least the representatives of the Department of Health and Community Services, had certainly indicated its interest in the WRC facility and services.

Thus our early assessment of the role of the WCB in physical rehabilitation of injured workers was that though it was a current direct provider as well as purchaser, it was not comfortable in its provider role and leaned towards greater purchase, rather than direct provision of service.

The project objectives developed by the WCB, however, had judiciously included a number of specific assessments to be conducted before coming to a more definitive conclusion on its future role in physical rehabilitation. The major findings of these assessments are discussed below.

3.2 The Centre's Services

The Workers' Rehabilitation Centre's services and rehabilitation services provided by other agencies in the province were to be assessed, along the criteria of:

- Cost effectiveness
- Quality
- Availability

- Accessibility and timeliness
- Effectiveness for preparing the injured worker for employment readiness

3.2.1 Cost Effectiveness

Effectiveness indicators include quality, availability, accessibility and so on which are discussed below.

Cost comparisons are difficult as it is rarely possible to find an identical situation with which to compare. Along every measure we were able to identify, however, the Workers' Rehabilitation Centre does appear to compare favourably.

The average patient day cost charged by Centre to the WCB for inpatient care is much lower than what is charged by hospitals used by the WCB for inpatient rehabilitation services. The Centre charges the same rate for full day patients as inpatients, on the principle that employers at a distance should not be penalised. There is no comparable full day rehabilitation program in the New Brunswick system with which this cost can be compared; but even the inpatient rate compares well with the charge backs to the Saskatchewan WCB from Wascana Rehabilitation Centre, and those to the Ontario WCB from Downsview, for full day programs exclusive of accommodation.

The Centre's charges for out patient visits also seem reasonable in comparison to those charged by the public system and by private clinics.

The costs of provision of prosthetic and orthotic services at the Centre compares well with those of private suppliers.

Finally, the Centre's overall budget (and thus its cost to WCB) is projected to decrease slightly in 1992; this is in contrast to anticipated continuing increases in total medical assistance payments.

All of the above does not necessarily mean that the costs of the WRC are appropriate. They may be too high or too low, in one aspect or other or as a whole. They must be considered in relation to effectiveness.

3.2.2 Quality

Our consultants found no glaring deficiencies in the quality of the rehabilitation services delivered by the Centre. Nevertheless a number of recommendations were made, especially focusing on relating programs and activities to clinical goals and evaluating performance.

We were unable to directly assess the quality of services delivered by the public health system or private providers. Some general quality indicators frequently utilised are:

- Accreditation; the hospitals in which injured workers are treated are generally accredited. The WRC is not and neither are the private clinics.

- Qualifications of rehabilitation staff. Medical specialists are available in the general system but not on staff at the WRC. Qualifications of other rehabilitation staff at the Centre appear to at the least match those of other providers in the province.

- Stakeholder satisfaction. Other providers generally had good regard for the WRC but there were mixed views in our information gathering from some stakeholders. We do not have a basis for comparing stakeholder satisfaction with rehabilitation services to injured workers by other providers.

- Quality management. Quality management including utilization review is fairly well developed in the public health system, though not particularly focused on rehabilitation. Quality management has made considerable progress at the WRC, but is still somewhat uneven.

3.2.3 Availability

The WRC represents the greatest concentration of rehabilitation resources, in terms of staff, facilities and equipment, in the province.

Not all rehabilitation services are equally scarce in New Brunswick. Private physiotherapy clinics have been increasing in numbers; and specialty physicians are all outside the Centre, though far from evenly distributed. Nevertheless, it is clear that without WRC, injured workers could not get adequate services through the public or private sectors.

3.2.4 Accessibility

In terms of language accessibility, the WRC's efforts have been exemplary. Francophone workers cite it as a strength and, as far as we could determine, Anglophone workers do not appear to resent the Centre operating in both languages.

Physical (geographic) accessibility is an evident weakness of the Centre. New Brunswick is not a large province, but the drive from one end to the other is arduous, particularly for those with painful injuries.

The regional hospital system offers a geographic accessibility that could never be matched by a centralised specialty service, especially one located in one end of the province. However, their services are not intended to provide for many of the special rehabilitation needs of injured workers.

3.2.5 Timeliness

The WRC's performance in relation to this criteria is mixed.

Waiting time for admission is four to six weeks and compares very favourably with waiting time for admission to rehabilitation centres for injured workers in other provinces. However, injured workers are not usually referred for admission until months after their injury.

Waiting time from referral until seen for rehabilitation services from other providers such as medical specialists and physiotherapy clinics is about four to seven weeks, which is consistent with the waiting time until seen at the WRC. Time from injury to referral is much shorter for these other providers, but it must be noted that time from injury to referral to the WRC is not controlled by the Centre. Nor is this time interval well controlled by the entire WCB organization.

3.2.6 Effectiveness in Preparing the Injured Worker for Employment Readiness

We could not evaluate the performance of external providers of rehabilitation services in achieving this objective, from the information available.

It is known that some injured workers admitted to full day and inpatient programs at the Centre are discharged because they are waiting to see a specialist. The majority, however, are considered prepared for employment when discharged. About 15% of all admissions are referred to Physical Assessment Committee for a decision. Of these, 25 to 30% are assessed as prepared for employment, and about 50% are referred to Vocational Rehabilitation. Of the 50% referred for Vocational Rehabilitation, between 50 and 60% are prepared for employment on closure, a good rate relative to other provinces.

Thus we deduce that the vast majority of workers admitted to the Centre are eventually considered prepared for employment. Some of these assessments are reversed once the worker gets home.

One issue which emerged in relation to preparation of the injured worker for employment is the responsibility of the injured worker for themselves outside of treatment. Workers using the WRC as a day program and workers receiving rehabilitation services from other providers, are responsible for themselves outside of treatment, whereas inpatients are currently in a much more regulated and less responsible context.

3.3 Alternatives to the Present Model of Physical Rehabilitation Within the Present Health Care Services in New Brunswick

A physical rehabilitation services master plan is not yet available from the province. Strong bases for physical rehabilitation exist only in the three southern cities and there is little likelihood of substantial short term improvement. Even the role of the Forest Hill Rehabilitation Centre remains unclear.

The physical rehabilitation services which are available in the public system attempt to meet primary and secondary rehabilitation needs and despite financial incentives, do not view injured workers as a priority or offer any clinical management protocols specific to employment injuries. Private clinics may in fact give injured workers priority since they are a major source of business, but they constitute only one aspect of rehabilitation, and they too do not appear to provide or be developing any management protocols specifically directed towards cost effective treatment of injured workers.

3.4 Alternative Models for the Delivery of Rehabilitation and Treatment Services for the Injured Worker Population of New Brunswick

The alternative models for delivery of rehabilitation services for injured workers which we identified included:

- Closing the Centre entirely and purchasing all services through other providers
- Turning ownership and operations over to the public health system,with access to injured workers
- Continued ownership and operations by the WCB, but with access to the civilian population

- Continued ownership and operations by the WCB, with access restricted to injured workers
- Development of a second specialized rehabilitation centre in the northern part of the province

All these alternatives were considered along the same criteria used for analysis of the Centre, that is:

- Cost effectiveness
- Quality
- Availability
- Accessibility
- Timeliness
- Effectiveness in preparing the injured worker for employment readiness

The analysis showed that continued ownership and operations by the WCB, with access restricted to injured workers, is the most advantageous option available to the Board to provide for the needs of injured workers at present. Selected access to civilians should be considered once clinical program areas have been more fully developed.

3.5 Recommendations with Respect to the Workers' Rehabilitation Centre's Present and Future Role in Rehabilitation Services for the Population in General and Injured Workers in Particular

The recommendations, in Section 4, address the WRC's role, relationships to other WCB programs and general operations.

3.6 The Workers' Rehabilitation Centre's Efficiency in Program Management and Coordination

We assumed this objective incorporated effectiveness as well as efficiency. The services most closely approximating programs at the WRC are the Prosthetics/Orthotics service, and the Pain Control Unit. In neither case are the full costs of the service attached to the "program" budget. Both were assessed as operating efficiently in comparison to alternatives elsewhere.

Program management, however, requires clear definition of the program and its goals and objectives, and evaluation criteria in terms of structure, processes, and outcomes. In this sense program management at the Centre is only at the conceptual stage. Our information gathering and workshop found interest in, some understanding of and readiness for the concept.

The WRC may also play a role in coordination of/with other programs provided by the WCB. The need for closer coordination with Vocational Rehabilitation and with early injury assessment and intervention emerged very clearly.

3.7 The Timeliness of Completion of the Physical Rehabilitation Process

To assess timeliness of completion of rehabilitation would require a profile of the nature of injuries treated and standards for completion of rehabilitation for profile components. A small random sampling of files and an analysis of diagnostic codes provided us with only a very preliminary profile of the nature of injuries, and timeliness standards for the treatment of injuries were not identified at all at the WRC.

The length of stay of five weeks at the WRC is quite consistent with program length of stay in other rehabilitation centres, such as Wascana and Downsview. As noted above, however, admission to the program is months after the injury. Furthermore, referral and admission to other rehabilitation services, while faster, is uneven and certainly not standardised, reinforcing the need for better clinical management of all claims.

A fundamental principle of rehabilitation is early intervention. Yet in the current clinical management of injured workers, early intervention appears haphazard and a matter of good luck as much as good management.

3.8 A Budget Base Review/Operational Audit of the Workers' Rehabilitation Centre to Determine the Appropriateness of Present Services and Resources, Both Physical and Financial

The operations and resources of each department were reviewed, as well as those of the Centre as a whole. Recommendations were provided for each area. While some opportunities for improved efficiency were identified, a number of recommendations will require an investment of energy and some resources. We do not foresee overall savings, in the operation of the Centre.

4 Recommendations

The scope of this project, encompassing both a role study and an operational review, generated a large number of recommendations, ranging from the broad to the specific. To avoid overwhelming the reader, only the recommendations relating to the role and operations of the Centre as a whole are presented in this Executive Summary. The individual operational reviews include 68 additional recommendations. They are consistent with and generally dependent on implementation of the recommendations regarding the Centre as a whole, and can be used to help structure an implementation plan for the Centre.

Role of the Centre

1. *The WRC should continue in its present role with a primary mission to the injured workers, and accountability to the WCB.*

2. *Following implementation of changes in operations, contracting to other users compatible with injured workers should be targeted, as there are considerable potential benefits in terms of quality, relationships and costs.*

3. *The Centre should be the arm of the WCB providing leadership, standards, and guidance for any clinical activity provided by the Board, whether provided at the Centre or elsewhere (see Clinical Leadership and Integration for details).*

4. *Clinically, the Centre should be more closely linked with other WCB services, but for day to day operations, it should be generally self sufficient.*

Structure of the Centre

5. *The WRC should have an appropriate and active governing body dedicated to the excellence of the Centre; which acts as a link between it and all stakeholders, acts as its emissaries, and brings external perceptions and experiences.*

6. *The membership of the governing body of the WRC should include representatives of employers and injured workers, as well as other organizations with whom good communications are important, such as the Family Practice chapter of the New Brunswick Medical Society.*

7. *The structure of the governing body must ensure coordination of objectives between the WRC and the WCB. Options will depend on the organization of the WCB itself, but may include a chairperson who is also chairperson of the WCB, if a full time chairperson is retained; a chairperson who is the general manager/CEO of the WCB; a chairperson who is an associate or executive director with responsibility for client services.*

Clinical Leadership and Integration

8. *The recently adopted mission statement stating the focus and philosophy of the Centre should be a visible point of reference within the facility and on appropriate documents and reports.*

9. *The Centre needs to carefully assess and document the types of patients and difficulties being treated there and through other WCB services, and then decide on the specific programs that would direct treatment to these various groups of workers.*

10. *The mission statement should then be matched with a clear statement of goals and objectives.*

11. *Consideration should be given to combining the senior medical positions for the Workers' Compensation Board and the Workers' Rehabilitation Centre. This would be a challenging position with expectations of innovation and research at the WRC, achieving accreditation for the Centre, affiliation with a teaching institution, staff interchange with hospitals, presentation and publication of papers, delegation of responsibility, and a team approach. Reimbursement and qualifications would have to be commensurate with the breadth of responsibilities.*

12. *The WRC should identify/develop protocols or standards for clinical management in identified program areas. The WRC should then be responsible for communicating these standards to all providers from whom rehabilitation services are purchased and facilitating quality management.*

13. *WRC should move toward program management, with each program having a particular clinical entity as its focus. Programs should be large enough that staff might be able to rotate through various programs in the Centre and yet specific enough to allow them to become experts in their field.*

14. *Within each program team, one member should be identified as the rehabilitation manager and the primary liaison for the injured worker and all members of the team.*

15. *The roles of all disciplines should be reviewed and defined in relation to the program objectives.*

16. *Research should become an integral part of the WRC's mission. From this knowledge about the care of injured workers can be disseminated.*

17. *The WRC should provide leadership in triaging of injured workers, thus enabling earlier intervention for those who require the full services of the Centre.*

18. *The WRC should be providing guidance to other providers in early assessment and intervention. The possibility of contracting general practitioners in each of the WCB offices to provide early assessment and intervention should be explored.*

19. *Based on the knowledge and experience gained through its programs and research, the WRC should provide guidance to WCB and the Occupational Health and Safety Commission on primary prevention of workplace injuries and disabilities.*

Vocational Rehabilitation

20. *Vocational expertise should be established within the Centre as soon as possible to work with all identified programs. Linkage between the vocational worker and the client should take place as soon as possible following admission. Linkage should also be established as soon as possible with the injured worker's home unit*

21. *Vocational rehabilitation should be started much earlier. In most cases, the system does not begin to focus on alternative job options until 18 to 24 months post injury. This is much too late, as by then the vicious circle of factors that lead to chronicity are well ingrained, and very resistant to change.*

Operational Issues

22. *The accommodation and therapeutic services provided by the Centre should be functionally separated. There is inconsistency between the goals of the WRC and some of the in patient regulations and behaviour monitoring, which are also very time consuming. Accommodation should be provided as a hostel operation.*

23. *A public relations plan, structure, and resources need to be identified and directed at injured workers, employers and other providers.*

24. *The continuing education priorities of the Centre as a whole need to be identified and a plan for addressing them developed. Once the Centre's initial program areas are identified, continuing education should be targeted towards them. One of the first educational priorities should be directed towards facilitating and carrying out basic research.*

25. *A clinical information system is badly needed. Whatever information system is selected should be compatible with Hospital Medical Records Institute rehabilitation systems so that comparisons can be made.*

26. *A human resources presence must be provided at the Centre, to facilitate consistency between WCB human resources policy and procedures and the Centre's objectives and operations.*

Administrative Leadership

27. *Administration should, together with the WCB, initiate a review of the Centre's functions and its total leadership resources, identify the greatest gaps, and plan positions accordingly, in particular the use of the position of Director of Therapeutic Services.*

28. *Administration must provide leadership and support in the implementation of operational and clinical recommendations, such as:*

- *Including outcome indicators, monitoring mechanisms, and time frames in its annual workplan*
- *Implementing a Centre wide orientation program*
- *Developing Centre wide continuing education priorities and a strategy for meeting them*
- *Developing a public relations plan and structure*

- *Promoting and structuring research, beginning with ensuring that information gathering mechanisms and systems are in place*
- *Developing a team/program orientation to the major functions of the Centre*
- *Facilitating separation of the accommodation and therapeutic services of the Centre.*

29. *A five year implementation plan should be developed mapping out all operational objectives with a monitoring schedule.*

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1 Introduction

One of the 1991 goals of the Workers' Compensation Board was "to conduct a budget based review and role study for the Workers' Rehabilitation Centre. "

The Terms of Reference that accompanied the Request for Proposals for the study stated the following objectives:

1. To assess the Workers' Compensation Boards' present role of physical rehabilitation of injured workers.

2. To assess and analyze the Centre's services, and treatment and rehabilitation services provided by other agencies, along the following criteria:

   Cost effectiveness
   Quality
   Availability
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   Effectiveness for preparing the injured worker for employment readiness

3. To determine whether alternatives to the present model of physical rehabilitation exist within the present Health Care Services in New Brunswick.

4. To recommend appropriate alternative models for the delivery of rehabilitation and treatment services for the injured worker population of New Brunswick.

5. To make recommendations with respect to the Workers' Rehabilitation Centre's present and future role in rehabilitation services for the population in general and injured workers in particular.

6. To assess the Workers' Rehabilitation Centre's efficiency in program management and coordination.

7. To assess the timeliness of completion of the physical rehabilitation process.

8. To conduct a Budget Base Review/Operational Audit of the Workers' Rehabilitation Centre to determine the appropriateness of present services and resources, both physical and financial.

These were ambitious objectives. Our report presents our findings and recommendations as closely as we were able to determine them and includes either in the body or appendices information on which these were based.

2 Study Methodology

In order to address both the role study and operational review of the Workers' Rehabilitation Centre, our methodology incorporated a number of processes.

2.1 Information Gathering

The identification of the current injured workers' rehabilitation system in the province.

Information was obtained on the use of the Workers' Rehabilitation Centre and the use of general hospitals by injured workers. The tracking of rehabilitation services used and time intervals between them carried out on a sampling of claims for the Bathurst project also provided perspectives. Provincial rehabilitation resources such as facilities, specialty physicians and other rehabilitation professionals were identified. The views of key informants including providers, injured workers and their representatives, Workers' Rehabilitation Centre staff, and Department of Health and Community Services representatives were obtained.

The alternatives for provision of injured workers' rehabilitation services

These were developed through interviews with key informants and discussion with providers of rehabilitation services to injured workers in Ontario, Saskatchewan, and Alberta.

2.2 The Operational Review of the Workers' Rehabilitation Centre

Information was obtained on the Centre as a whole and on each of its departments, collected in a consistent format. All departments but two were then visited by a consultant with appropriate expertise. Due to weather restrictions, the remaining two had teleconference calls. In addition a separate cost review of prosthetic and orthotic services was carried out.

2.3 Synthesis of Information

A workshop was held of all WRC management, the project Steering Committee, and the major consultants. The information gathered to date was circulated prior to or reviewed at the workshop.

The workshop was the means for synthesising the information, and forging a recommended role, structure and operations for the Centre.

2.4 Reporting

All consultants wrote individual reports and these were circulated to the project Steering Committee and Centre management, and discussed with both groups. For purposes of this report, however, their findings and recommendations were consolidated.

2.5 Support

The project was supported by a Steering Committee, and greatly facilitated by the appointment of a project coordinator at the Workers' Rehabilitation Centre. The Project Steering Committee membership, list of consultants and list of external persons consulted are found in Appendices A to C.

3 Summary of Findings

The major findings regarding each of the project objectives are outlined below.

3.1 The Workers' Compensation Board's Present Role of Physical Rehabilitation of Injured Workers

The mission of the New Brunswick Workers' Compensation Board (WCB) is:

> "To provide compensation benefits, medical, physical, and vocational rehabilitation services when required to all injured workers covered under the Workers' Compensation Act, in a fair, prompt, humane,and effective manner, through the administration of no fault insurance for the registered employer community."

This mission statement indicates a clear responsibility on the part of the board for physical rehabilitation of injured workers.

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The Board also fulfils its responsibility for physical rehabilitation of injured workers by purchasing such services from public and private health care providers and more recently in the northern part of the province through the addition of a WCB physiotherapy clinic.

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All of these perceptions were reinforced by the fact that the public health system, at least the representatives of the Department of Health and Community Services, had certainly indicated its interest in the WRC facility and services.

Thus our early assessment of the role of the WCB in physical rehabilitation of injured workers was that though it was a current direct provider as well as purchaser, it was not comfortable in its provider role and leaned towards greater purchase, rather than direct provision of service. The development of the WCB physiotherapy clinic in Bathurst was not consistent with this role but could be regarded as an exception due to special circumstances.

The project objectives developed by the WCB, however, had judiciously included a number of specific assessments to be conducted before coming to a more definitive conclusion on its future role in physical rehabilitation. The major findings of these assessments are discussed below.

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3.2 The Centre's Services

The Workers' Rehabilitation Centre's services and rehabilitation services provided by other agencies in the province were to be assessed, along the criteria of:

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- Effectiveness for preparing the injured worker for employment readiness

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Finally, the Centre's overall budget (and thus its cost to WCB) is projected to decrease slightly in 1992; this is in contrast to anticipated continuing increases in total medical assistance payments.

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3.2.3 Availability

The WRC represents the greatest concentration of rehabilitation resources, in terms of staff, facilities and equipment, in the province.

Not all rehabilitation services are equally scarce in New Brunswick. Private physiotherapy clinics have been increasing in numbers; and specialty physicians are all outside the Centre, though far from evenly distributed. Nevertheless, it is clear that without WRC, injured workers could not get adequate services through the public or private sectors.

3.2.4 Accessibility

In terms of language accessibility, the WRC's efforts have been exemplary. Francophone workers cite it as a strength and, as far as we could determine, Anglophone workers do not appear to resent the Centre operating in both languages.

Physical (geographic) accessibility is an evident weakness of the Centre. New Brunswick is not a large province, but the drive from one end to the other is arduous, particularly for those with painful injuries.

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The regional hospital system offers a geographic accessibility that could never be matched by a centralised specialty service, especially one located in one end of the province. However, their services are not intended to provide for many of the special rehabilitation needs of injured workers.

3.2.5 Timeliness

The WRC's performance in relation to this criteria is mixed.

Waiting time for admission is four to six weeks and compares very favourably with waiting time for admission to rehabilitation centres for injured workers in other provinces. However, injured workers are not usually referred for admission until months after their injury.

Waiting time from referral until seen for rehabilitation services from other providers such as medical specialists and physiotherapy clinics is about four to seven weeks, which is consistent with the waiting time until seen at the WRC. Time from injury to referral is much shorter for these other providers, but it must be noted that time from injury to referral to the WRC is not controlled by the Centre. Nor is this time interval well controlled by the entire WCB organization.

3.2.6 Effectiveness in Preparing the Injured Worker for Employment Readiness

We could not evaluate the performance of external providers of rehabilitation services in achieving this objective, from the information available.

It is known that some injured workers admitted to full day and inpatient programs at the Centre are discharged because they are waiting to see a specialist. The majority, however, are considered prepared for employment when discharged. About 15% of all admissions are referred to Physical Assessment Committee for a decision (see Appendix F). Of these, 25 to 30% are assessed as prepared for employment, and

about 50% are referred to Vocational Rehabilitation. Of the 50% referred for Vocational Rehabilitation, between 50 and 60% are prepared for employment on closure, a good rate relative to other provinces.

Thus we deduce that the vast majority of workers admitted to the Centre are eventually considered prepared for employment. Some of these assessments are reversed once the worker gets home.

One issue which emerged in relation to preparation of the injured worker for employment is the responsibility of the injured worker for themselves outside of treatment. Workers using the WRC as a day program and workers receiving rehabilitation services from other providers, are responsible for themselves outside of treatment, whereas inpatients are currently in a much more regulated and less responsible context.

3.3 Alternatives to the Present Model of Physical Rehabilitation Within the Present Health Care Services in New Brunswick

A physical rehabilitation services master plan is not yet available from the province. As discussed in Section 5, strong bases for physical rehabilitation exist only in the three southern cities and there is little likelihood of substantial short term improvement. Even the role of the Forest Hill Rehabilitation Centre remains unclear.

The physical rehabilitation services which are available in the public system attempt to meet primary and secondary rehabilitation needs and despite financial incentives, do not view injured workers as a priority or offer any clinical management protocols specific to employment injuries. Private clinics may in fact give injured workers priority since they are a major source of business, but they constitute only one aspect of rehabilitation, and they too do not appear to provide or be developing any management protocols specifically directed towards cost effective treatment of injured workers.

3.4 Alternative Models for the Delivery of Rehabilitation and Treatment Services for the Injured Worker Population of New Brunswick

The alternative models for delivery of rehabilitation services for injured workers which we identified included:

- Closing the Centre entirely and purchasing all services through other providers
- Turning ownership and operations over to the public health system,with access to injured workers
- Continued ownership and operations by the WCB, but with access to the civilian population
- Continued ownership and operations by the WCB, with access restricted to injured workers
- Development of a second specialized rehabilitation centre in the northern part of the province

All these alternatives were considered along the same criteria used for analysis of the Centre, that is:

- Cost effectiveness
- Quality
- Availability
- Accessibility
- Timeliness
- Effectiveness in preparing the injured worker for employment readiness

Table 1 summarises the analysis of each of the alternatives. Each criteria was also rated along a five point scale, with 1 being most negative and 5 being most positive. Each criteria was assigned equal weight in the total score.

3.5 Recommendations with Respect to the Workers' Rehabilitation Centre's Present and Future Role in Rehabilitation Services for the Population in General and Injured Workers in Particular

Our recommendations follow in Section 4, addressing the WRC's role, relationship and general operations.

3.6 The Workers' Rehabilitation Centre's Efficiency in Program Management and Coordination

We assumed this objective incorporated effectiveness as well as efficiency. The services most closely approximating programs at the WRC are the Prosthetics/Orthotics service, and the Pain Control Unit. In neither case are the full costs of the service attached to the "program" budget. Both were assessed as operating efficiently in comparison to alternatives elsewhere.

Program management, however, requires clear definition of the program and its goals and objectives, and evaluation criteria in terms of structure, processes, and outcomes. In this sense program management at the Centre is only at the conceptual stage. Our information gathering and workshop found interest in, some understanding of and readiness for the concept.

The WRC may also play a role in coordination of/with other programs provided by the WCB. The need for closer coordination with Vocational Rehabilitation and with early injury assessment and intervention emerged very clearly.

Table 1

Assessment of Rehabilitation Alternatives

for Injured Workers

Option	Costs	Quality	Availability	Accessibility	Timeliness	Effectiveness	Total Points
1. Close the Centre and Purchase Services	- No WRC costs - Services purchased expensive 3	Dependent on quality management system of other providers 3	Very limited 1	Uneven and limited 1	Uneven but generally negative impact 1	Not a priority 1	10
2. Turn Centre over to Public System	- Would increase 1	Dependent on quality management systems of other providers 3	No change 3	No change 2	No change 3	Less priority 2	14
3. WCB Operated Centre with Access to Civilians	- Would benefit WCB 5	Accountable to WCB - bigger population - more variety - impact on motivation? - impede need to focus on injured worker programs? 4	No change 3	No change 2	Would be slower 2	Hasty introduction of other patients could distract from effectiveness for injured workers 2	18
4. WCB Operated Centre, Injured Workers Only	- Predictable and controllable 4	Accountable to WCB - potential for development of program excellence 4	No change 3	No change 2	Improvement can be managed 4	Improvement can be managed 4	21
5. Sponsor Second Centre in North	- Capital and ongoing costs 1	- Is population of injured workers sufficient? - Viability of recruiting staff? - Dilution of quality? 1	Improved 4	Improved 4	Improved 4	Potential improvement 2.5	15.5

3.7 The Timeliness of Completion of the Physical Rehabilitation Process

To assess timeliness of completion of rehabilitation would require a profile of the nature of injuries treated and standards for completion of rehabilitation for profile components. A small random sampling of files and an analysis of diagnostic codes provided us with only a very preliminary profile of the nature of injuries, and timeliness standards for the treatment of injuries were not identified at all at the WRC.

The length of stay of five weeks at the WRC is quite consistent with program length of stay in other rehabilitation centres, such as Wascana and Downsview. As noted above, however, admission to the program is months after the injury. Furthermore, referral and admission to other rehabilitation services, while faster, is uneven and certainly not standardised, reinforcing the need for better clinical management of all claims.

A fundamental principle of rehabilitation is early intervention. Yet in the current clinical management of injured workers, early intervention appears haphazard and a matter of good luck as much as good management.

3.8 A Budget Base Review/Operational Audit of the Workers' Rehabilitation Centre to Determine the Appropriateness of Present Services and Resources, Both Physical and Financial

The operations and resources of each department were reviewed, as well as those of the Centre as a whole. Recommendations were provided for each area. While some opportunities for improved efficiency were identified, a number of recommendations will require an investment of energy and some resources. We do not foresee overall savings, in the operation of the Centre.

4 Recommendations

The scope of this project, encompassing both a role study and an operational review, generated a large number of recommendations, ranging from the broad to the specific. To avoid overwhelming the reader, only the recommendations relating to the role and operations of the Centre as a whole are presented in this section. The individual operational reviews include 68 additional recommendations. They are consistent with and generally dependent on implementation of the recommendations regarding the Centre as a whole, and can be used to help structure an implementation plan for the Centre.

4.1 Role of the Workers' Rehabilitation Centre

1. *The Workers' Rehabilitation Centre should continue in its present role with a primary mission to the injured workers, and accountability to the Workers' Compensation Board.*

2. *Following implementation of changes in operations, contracting to other users compatible with injured workers should be targeted, as there are considerable potential benefits in terms of quality, relationships and costs.*

3. *The Centre should be the arm of the WCB providing leadership, standards, and guidance for any clinical activity provided by the Board, whether provided at the Centre or elsewhere. (See Section 4.3 for details.)*

4. *Clinically, the Centre should be more closely linked with other WCB services, but for day to day operations, it should be generally self sufficient.*

4.2 Structure of the Centre

5. *The WRC should have an appropriate and active governing body dedicated to the excellence of the Centre; which acts as a link between it and all stakeholders, acts as its emissaries, and brings external perceptions and experiences.*

6. *The membership of the governing body of the WRC should include representatives of employers and injured workers, as well as other organizations with whom good communications are important, such as the Family Practice chapter of the New Brunswick Medical Society.*

7. *The structure of the governing body must ensure coordination of objectives between the WRC and the WCB. Options will depend on the organization of the WCB itself, but may include a chairperson who is also chairperson of the WCB, if a full time chairperson is retained; a chairperson who is the general manager/CEO of the WCB; a chairperson who is an associate or executive director with responsibility for client services.*

4.3 Clinical Leadership and Integration

(see also Medical, Psychology, Physiotherapy, Occupational Therapy, Pain Control, Prosthetics/Orthotics, Nursing Services reviews)

8. *The recently adopted mission statement stating the focus and philosophy of the Centre should be a visible point of reference within the facility and on appropriate documents and reports.*

9. *The Centre needs to carefully assess and document the types of patients and difficulties being treated there and through other WCB services, and then decide on the specific programs that would direct treatment to these various groups of workers.*

10. *The mission statement should then be matched with a clear statement of goals and objectives.*

11. *Consideration should be given to combining the senior medical positions for the WCB and the WRC. This would be a challenging position with expectations of innovation and research at the WRC, achieving accreditation for the Centre, affiliation with a teaching institution, staff interchange with hospitals, presentation and publication of papers, delegation of responsibility, and a team approach. Reimbursement and qualifications would have to be commensurate with the breadth of responsibilities.*

12. *The WRC should identify/develop protocols or standards for clinical management in identified program areas. The WRC should then be responsible for communicating these standards to all providers from whom rehabilitation services are purchased and facilitating quality management.*

13. *WRC should move toward a program management approach, with each program having a particular clinical entity as its focus. Program teams should be large enough that staff might be able to rotate through various programs in the Centre and yet specific enough to allow them to become experts in their field.*

14. *Within each program team, one member should be identified as the clinical rehabilitation manager and the primary liaison for the injured worker and all members of the team.*

15. *The roles of all disciplines should be reviewed and defined in relation to the program objectives.*

16. *Research should become an integral part of the WRC's mission. From this knowledge about the care of injured workers can be disseminated.*

17. *The WRC should provide leadership in triaging of injured workers, thus enabling earlier intervention for those who require the full services of the Centre.*

18. *The WRC should be providing guidance to other providers in early assessment and intervention. The possibility of contracting general practitioners in each of the WCB offices to provide early assessment and intervention should be explored.*

19. *Based on the knowledge and experience gained through its programs and research, the WRC should provide guidance to the WCB and the Occupational Health and Safety Commission on primary prevention of workplace injuries and disabilities.*

4.4 Vocational Rehabilitation

20. *Vocational expertise should be established within the Centre as soon as possible to work with all identified programs. Linkage between the vocational worker and the client should take place as soon as possible following admission. Linkage should also be established as soon as possible with the injured worker's home unit.*

21. *Vocational rehabilitation should be started much earlier. In most cases, the system does not begin to focus on alternative job options until 18 to 24 months post injury. This is much too late, as by then the vicious circle of factors that lead to chronicity are well ingrained, and very resistant to change.*

4.5 Operational Issues

22. *The accommodation and therapeutic services provided by the Centre should be functionally separated. There is inconsistency between the goals of the WRC and some of the in patient regulations and behaviour monitoring, which are also very time consuming. Accommodation should be provided as a hostel operation.*

23. *A public relations plan, structure, and resources need to be identified and directed at injured workers, employers and other providers.*

24. *The continuing education priorities of the Centre as a whole need to be identified and a plan for addressing them developed. Once the Centre's initial program areas are identified, continuing education should be targeted towards them. One of the first educational priorities should be directed towards facilitating and carrying out basic research.*

25. *A clinical information system is badly needed. Whatever information system is selected should be compatible with Hospital Medical Records Institute rehabilitation systems so that comparisons can be made.*

26. *A human resources presence must be provided at the Centre, to facilitate consistency between WCB human resources policy and procedures and the Centre's objectives and operations.*

4.6 Administrative Leadership

(see also Administration Operational Review)

27. *Administration should, together with the WCB, initiate a review of the Centre's functions and its total leadership resources, identify the greatest gaps, and plan positions accordingly, in particular the use of the position of Director of Therapeutic Services.*

28. *Administration must provide leadership and support in the implementation of operational and clinical recommendations, such as:*

- *Including outcome indicators, monitoring mechanisms, and time frames in its annual workplan*
- *Implementing a Centre wide orientation program*

- *Developing Centre wide continuing education priorities and a strategy for meeting them*
- *Developing a public relations plan and structure*
- *Promoting and structuring research, beginning with ensuring that information gathering mechanisms and systems are in place*
- *Developing a team/program orientation to the major functions of the Centre*
- *Facilitating separation of the accommodation and therapeutic services of the Centre.*

29. *A five year implementation plan should be developed mapping out all operational objectives with a monitoring schedule.*

5 Role Review Findings

5.1 Introduction

The role of the Workers' Rehabilitation Centre was reviewed primarily from the perspectives of its current role, the status and outlook for other rehabilitation services in the province, effective case management and the forecasted need for injured workers' rehabilitation services. The role conclusions in the final section of this chapter also reflect the results of the Project Workshop and the implications of the recent Task Force report.

While it is beyond the scope of this review to fully determine all the features of an integrated system for injured workers' rehabilitation, the Centre's role is significantly intertwined within a larger system. As a consequence, the recommendations made in this report will be based upon findings related to the total system environment. One inescapable fact is that the Centre is the largest specialized facility with the most comprehensive range of rehabilitation programs in the province. Its continuation as a significant component of the physical rehabilitation services system is not in question. it is rather the nature of its involvement.

A variety of issues, considered interdependently, bear on the role of the Centre. This review has attempted to consider each of them. These issues include: the structure and resourcing of provincial physical rehabilitation services; the injured workers' rehabilitation "system"; the views of stakeholders and service providers; the experiences of other jurisdictions; the Bathurst decentralization experience; the principles of injured workers' rehabilitation; and the program and staffing strengths and weaknesses of the Centre.

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5.2 Current Role

The Workers' Rehabilitation Centre is the treatment facility of the Workers' Compensation Board of New Brunswick. It provides elevated secondary and tertiary physical rehabilitation services to injured workers who qualify for benefits and services under the New Brunswick Workers' Compensation Act.

The Centre is capable of serving 170 patients on a daily, five days per week basis. It has the capacity to accommodate 130 of these patients in a hostel-type setting.

Rehabilitation services at the Centre are delivered by multi-disciplinary teams of specialized health care professionals. The services include general medical, physical and psychological assessment and treatment; education in personal physical care and safe work methods; development of skills for independent living; work simulation and hardening and vocational assessment; assistance with reintegration into the workplace, home and community; and, when applicable, a post discharge follow-up and maintenance program.

The large majority of injured workers have all their rehabilitation needs served outside the Centre. Only 2300 (20%) of some 10,000-12,000 workers who experience lost-time injuries each year are served by the Centre. The large majority obtain their services from private medical and rehabilitation practitioners and in general hospitals. The costs of these latter services are covered by the Workers' Compensation Board.

Patients are admitted to the Centre for either one or both of the following reasons:

- They require an extended period of intensive rehabilitation to treat injuries that have not responded to previous community-based or general hospital treatment

- They are thought to be poorly motivated or abusing their entitlement to compensated absence from work

- In the case of day program patients, they also may use the Centre as an alternative to other rehabilitation services in the region.

Some of the features of the Centre are:

- Excellent equipment and facilities for rehabilitation
- Good staff/patient ratio
- More effective patient exercise/recreation program
- Attractive site
- Encourages ambulation
- Work hardening program (currently being implemented)
- Psychology service
- Prosthetic and orthotics service
- Vocational rehabilitation and assessment
- Assessment of functional capacity
- Pain control program.

5.3 Rehabilitation Services in New Brunswick

5.3.1 The Provincial Hospital System and Specialty Physicians

In spite of considerable good intentions and efforts by all interested parties during the 1980's, this province has been unable to develop a physical rehabilitation services master plan.

Under the current circumstances strong bases for physical rehabilitation services exist only in the three southern cities and decentralization would require considerable improvements in the northern regions. There is little likelihood of substantial short term improvement in the availability of physical medicine and rehabilitation specialists in Edmundston, Campbellton, Bathurst and the Miramichi. Without the local availability of these specialists and given their general shortage throughout the

province, it is unlikely that there will be much medium term reduction in the need for northern patients to travel south for secondary and elevated secondary rehabilitation services. The Campbellton, Chaleur, Edmundston and Miramichi hospitals are unlikely to attract physiatrists. Outreach from Fredericton, Moncton and Saint John will continue to be necessary and should be more formally established.

The recommendations in the Discussion Paper on Integrated Physical Rehabilitation Services, prepared by a joint committee of the Workers' Compensation Board and the Department of Health and Community Services, do not include any changes in governance or administration of the system's components that could result in a stronger structured approach to integration.

There is an inconsistency in role allocation as determined by this committee and the current and planned roles of the regional hospitals in Moncton, Saint John and Fredericton as defined in the Hospital System Master Plan. Clearly these hospitals will have an ongoing elevated secondary rehabilitation services role. Clarification of these roles in relation to those of the Workers' Rehabilitation Centre, the Forest Hill Rehabilitation Centre and the proposed Northern Rehabilitation Centre was not given by the committee that studied integration. This is a critical factor in determining the role of the Centre. Considerable development is contemplated for Bathurst to the level of services currently available only in the three southern cities. The probability of achieving such a result in the medium term is an issue that should be carefully considered.

It is anticipated that the new hospital services master plan will reaffirm the availability of specialized rehabilitation in regional hospitals, but there is a shortage of physiatrists to support such services. As a result northeast elevated secondary and tertiary service will probably be concentrated in Bathurst.

There are currently only four physiatrists practising in the province. Achieving the Physician Resources Advisory Committee's target of eight for the province means

attracting one more to each of Moncton, Saint John, Edmundston and Bathurst. While recruitment should be successful for Moncton and Saint John, there is significantly less probability of success for Edmundston and Bathurst in the medium term.

The Forest Hill Rehabilitation Centre has recruited a second physiatrist to start in 1993. As this will increase the Fredericton number beyond the assumed provincial target, consideration must be given to the outreach role the two FHRC physiatrists will perform. Perhaps there will be an opportunity for them to hold more clinics in the north and to be more active with injured worker services in Fredericton and at the Workers' Rehabilitation Centre.

The Saint John Regional is planning to recruit a second physiatrist. The combined needs of both services could support two and an integrated service might be a recruitment attraction.

5.3.2 Saint John/Region 2 Services

Those consulted locally feel there is no need for two independent facilities in the Saint John area. With decentralization of injured workers' treatment the WRC might have excess capacity and the remaining admissions would be primarily ambulatory care. It would be difficult to accommodate all Region 2 injured worker services at SJRH, and cost-effectiveness would also be questionable. Alternatively the variety of rehabilitation, rheumatology and geriatric services and the volumes at SJRH could not be accommodated at WRC. A neuroscience service would still be required at SJRH, but patients could be transferred to Grand Bay for rehabilitation and recovery. Chronic patients at SJRH would still require on-site rehabilitation services. Roles would have to be clearly defined.

5.3.3 Professional Rehabilitation Resources

All levels of physical rehabilitation services depend significantly on the availability of physiotherapists and occupational therapists. Consequently their distribution throughout the province is a significant factor in the capability of each region to provide needed services.

Two regions, Chaleur (6) and Miramichi (7) are relatively poorly resourced. The Saint John region (2) is the best resourced due to the staffing at the Workers' Rehabilitation Centre.

It was suggested that transferring WRC staff to Chaleur would be an important impetus to development of an integrated service for the northeast.

If each region were to be equally resourced based on population, (a condition necessary for full decentralization and integration),a redistribution of resources would be required from region 2 (Saint John) to regions 6 (Bathurst) and 7 (Miramichi).

5.4 Managing the Care of Injured Workers

The effectiveness of the total workers' rehabilitation "system" has a large bearing on admissions to the Centre. There is a perception of system abuse. Reducing this will require more rigorous assessment at intake and regular monitoring.

Concerns were raised about: the subjectivity of assessment and treatment methods; excessive lost time days with no treatment occurring; the lack of set standards and effective monitoring of services provided by private practitioners.

If further decentralization is pursued it will be important to improve program management to ensure continuity of treatment.

Considerable comment and advice were given on the management of injured workers' treatment in the province. While this issue is broader in scope than the Centre's role, the effectiveness of the total workers' rehabilitation "system" has a large bearing on admissions to the Centre.

The number of work-related injury cases is falling in the province, yet workers are off the job for longer periods. This is because primary treatment is not monitored, is ineffective and is delayed. The workers and their family physicians have too much freedom regarding treatment.

Injured workers should be treated more like injured athletes. Physicians should not wait for pain to subside before initiating rehabilitation, but start it immediately. Injured workers should be encouraged to continue with regular exercise during and following recovery. Assessment and treatment methods are too subjective. There are too many lost time days with no treatment occurring. Benefits should be limited for soft tissue injuries, unless a properly trained person determines more treatment is required. WRC/WCB need to give more direction to the treatment. WCB should put in place an obligatory, after 3 weeks, soft tissue injury treatment program that is similar to Ontario's.

Treatment at WRC is perceived as too late and too intense.

It has been assumed that any general medical practitioner can direct effective treatment. No standards are set nor is there effective monitoring of services provided by private practitioners. The key to successful treatment is having appropriately trained general practitioners who are willing to spend the time. The emphasis should be on involving general practitioners who have done the four week elective in physical medicine and rehabilitation. A rehabilitation education program should be developed for specifically for these physicians.

The system needs more direction. There is a need to spend money on care management to save money on benefits. More effective case management and treatment protocols are required. WCB should establish protocols, provide specific education to physicians, run an outcomes-oriented Quality Assurance/Utilization Review program and purchase blocks of service from regional hospitals and specialists.

The overall cost of WCB is strongly influenced by the efficiency and effectiveness of the treatment program. Yet there is no evidence of coordinated care management from time of injury to return to work.

The WCB is unable to demonstrate efficiency, effectiveness and positive outcomes from its treatment programs because no research is being done. The focus should be on quality and the result should be reduced costs of treatment and benefits.

There are holdups throughout the system. Referrals from the centre to specialists wait 6 weeks - the fee premium apparently makes no difference. It was observed that this is the most significant holdup in the treatment process. Scheduled specialist clinics with sessional payments have been recommended by the Centre's staff but approval to implement has not yet been given by head office.

5.5 Other Perspectives on the Role of the Centre

5.5.1 Stakeholders and Service Providers

There is stakeholder support for the further integration and decentralization of physical rehabilitation services. The public system would like to access such a facility and some WCB cases could be better handled in the general system. Both systems currently have a heavy presence in the south. Several advantage and disadvantages were identified:

- It is felt that workers might get more intensive care earlier and their treatment would be more professionally directed. Workers might benefit from the motivational impact of regular patients.

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- There would be greater involvement by specialists in workers' cases.
- With the large number of ambulatory patients at WRC, there might be greater emphasis on discharging if civilian patients were also treated there.
- Preferential treatment of injured workers might be a problem.
- The WRC might become underutilized.
- Comparative costs would have to be carefully evaluated.
- Rehabilitation services would have a higher profile in the regional hospitals.

5.5.2 Injured Workers Rehabilitation System in Other Provinces

Alberta, B.C. and Ontario all have separate workers' rehabilitation facilities.

The Wascana Rehabilitation Centre in Saskatchewan has a comprehensive provincial role that includes injured workers. It is considered to be an effective model for providing injured worker and general public services in a single facility.

However, claims costs in Saskatchewan in 1989 were almost double those of New Brunswick despite 20% fewer claims (reference WCB - Alberta).

Ontario has regional community clinics and evaluation centres. It has been observed that this is a very expensive delivery method. Case management and control is not as effective as expected and duration of benefits has not decreased.

5.5.3 Impact of Bathurst Regionalization Project

This project has accelerated the rehabilitation process for injured workers from the northeast. Use of the WRC by injured workers from that area decreased significantly between 1989 and 1991. For the northeast counties use of the WRC decreased from 21% to 11.2% of claimants in the two years reviewed.

Total time from injury until seen at WRC for the Bathurst sampling in 1991 was still 21 weeks, or five months. For the balance of the province it was even higher.

A high proportion of system users surveyed in the Bathurst project rated the WRC service to be good to very good. The same proportion were satisfied or very satisfied with the amount of services provided by the WRC. There was less satisfaction with the amount of time it took to get an appointment there.

5.5.4 Employer Roles Related to Workers' Compensation

Employers get very little clinical information on their injured workers that is necessary for planning prevention and job reentry programs. They are not doing enough to modify the workplace or provide alternative work to accommodate returning workers. More employers should have formal work reentry programs. WCB should be working more actively with employers to ensure they are prepared to take workers back - similar to the discharge planning function in hospitals. In all cases a return to work date should be established jointly by the employer, the treating physician and the WCB.

Sector associations would do more about injury prevention if they had more information on the performance of individual companies. They could then exert peer pressure for performance improvement. There is generally insufficient attention to prevention and education.

5.5.5 Forecasted Need

Employment Trends in New Brunswick

As the Workers' Compensation Board attempts to define an appropriate role for its Workers' Rehabilitation Centre, it is useful to look at the potential for injuries over the next several years. Before that can be done, it is necessary to look at the state of the economy, its industries, employment and the influences affecting activity. After all, the nature and volume of employment are significant factors influencing injury potential.

The New Brunswick Economy

The New Brunswick economy out-performed the other Maritime provinces regarding employment and economic growth over the past ten years. The province has a more diversified economy than either Nova Scotia or Prince Edward Island including five major primary resource sectors including agriculture, fisheries, forestry, energy and mining. The province has benefitted from major construction activity; first the Point Lepreau power facility and later the Canadian Navy frigate program. In addition, New Brunswick communities (notably Moncton) have shown tremendous innovation and the ability to change focus whenever a potentially catastrophic event such as the closing of a major employment source (re Canadian National Railways) occurs.

New Brunswick also has a substantial manufacturing sector. However, this sector is highly related to the primary resource industries of the province. As a result, this sector is extremely vulnerable to those activities influencing the primary resource industries. However, the usual pattern over the past ten or fifteen years, has been that if one or two of the sectors were in a slump, the others were not. Rarely were circumstances such that every sector was in a downturn.

The past five years have seen the advent of several major trends that will significantly affect New Brunswick industry. These include the latest round of negotiations of the

GATT, the Free Trade Accord, fisheries stock depletion and increasing globalized trade. These trends pose both opportunity and risk to the health of New Brunswick's economy and the employment capacity.

Conclusion

The primary sectors of the New Brunswick economy are experiencing tremendous upheaval and are undergoing massive transition. The result at the end of this rapid restructuring is quite difficult to predict, regarding employment. However, there are several logical conclusions that can be reached. They include:

- Fewer individuals will be employed in these industries
- Skill levels of those working will be higher
- More technology and mechanization

Based on these outcomes there will be a reduction in the rate of injuries for these industries. There will also be a related contraction in the size of the labour force. This will have implications regarding premiums to the Worker's Compensation Board that must be addressed. The WCB works on the premise that over the long run premiums will equal benefits paid. However, several of these sectors are high premium and high claim industries, particularly forestry. Given the level of existing WCB debt and the potential for dramatic loss in premiums paid, based on the labour force contraction, there is a strong possibility that a major cash flow issue will have to be faced.

The Workers' Compensation Board should be aware that their present actuarial tables may not be valid in the near future. These labour force trends must be monitored closely and a complete review of how premiums are set must be considered a priority.

5.6 Service System Principles

Any review of health services delivery or a specific facility should be undertaken in the context of general service system principles or criteria. There are six such principles to be considered in determining the role of the Centre as follows:

5.6.1 Quality

The most critical factor in relation to health care delivery is quality. Service users are entitled to receive services that are of high standard. The provision of these services wherever they are provided must be of consistently high quality. Services must be consistent with the clinical goals. In the case of rehabilitation, quality must address timeliness, frequency and intensity of treatment.

5.6.2 Accessibility

Residents of any area in the province should not be impeded in their access to necessary services. Therefore, the WCB has the obligation to provide local services or to provide alternative means to transport patients to services or providers to patients. Appropriate treatment within a reasonable time should be delivered as close as possible to the injured worker's home area. Accessibility also incorporates language accessibility.

5.6.3 Affordability

The users ability to pay (eg. for transportation or room and board) should not be a determinant of access to necessary services.

5.6.4 Integrity

Organizations delivering health services should not eliminate services or restrict access to necessary services when such action would transfer pressure to provide services to other organizations. In the unique WCB case, in which responsibility for the treatment of a special population group is acknowledged, this principle implies that

its programs should not be reduced if there will be adverse consequences for the operations and cost of the public health care system.

5.6.5 Equity

As rehabilitative care is a right of injured workers, it is not justifiable for the WCB to provide a greater intensity of services to its users in a particular area of the province than are generally available in the province.

5.6.6 Efficiency

The WCB has an obligation to obtain the greatest value-for-money from the funds entrusted to it from provincial employers. This means that any changes should not lead to an increase in the cost of operating the board (**budget neutrality**); and expenditures on treatment should be increased if the overall **cost-effectiveness** of the WCB is improved

5.6.7 Prevention

Both employers and employees must accept responsibility for minimizing workplace injuries the duration of absences from work following injury.

The various options for roles of the Centre must be assessed in relation to their impact on each of these principles.

5.7 Conclusions

Two issues are fundamental in understanding and determining the role and operation of the WRC: the appropriateness of a specialized facility within the overall continuum of the provincial injured workers rehabilitation "system"; and the nature of jobs and employment in the future in view of the provincial economic outlook.

While the service system principles stated in the previous section should be a major consideration in the determination of the future role for the centre, other factors are also of practical importance.

Should it be assumed, for example, that there will be a significant reduction in the need for the specialized services currently provided at the centre as a result of economic change; by improvements in the management of primary and secondary treatment of injured workers; or by increased attention to accident prevention?

And will the general hospital system, the Chaleur Regional Hospital in particular, be successful in its planned development of secondary and elevated secondary services?

Will the provincial government be able to reallocate resources to enable the improvement of general hospital rehabilitation services?

Or will workers themselves take steps to reduce their unnecessary utilization of the services provided by the Workers' Compensation Board?

Definitive answers to these questions are not possible, but it does seem reasonable to expect that the impact of such developments will be reduced utilization of the Centre for the types of cases it currently treats. This presents three significant opportunities for this excellent physical facility:

1. To serve more workers requiring the unique services of the Centre earlier and with greater intensity.

2. To serve public patients from throughout the province who could benefit from the Centre's specialized services who are able to use such services on an outpatient or hostel basis.

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3. To serve all residents of Region 2 for a broader range of outpatient rehabilitation services - eg. sports injuries and rehabilitation following discharge from hospital.

Four options were considered for the future role of the Workers' Rehabilitation Centre. They are:

1. Continued ownership and operation by the WCB, serving only injured workers.

2. Continued ownership and operation by the WCB, with services for both injured workers and the general public.

3. Transfer of ownership and operation to the public health system, with WCB paying or contracting for use by injured workers.

4. Closure with WCB contracting with general hospitals and the Forest Hill Rehabilitation Centre for services to injured workers.

Each option was considered in terms of its impact on the access to appropriate care and the recovery of injured workers, acceptance by stakeholders and cost-effectiveness of WCB services - ie. the service system principles previously identified. It is unreasonable to expect that any one of these alternatives will produce the best solution in relation to all service system principles. Tradeoffs are necessary and, consequently, some principles will have to be given greater weight than others. For purposes of selection we have considered seven of these principles to be most important: quality, accessibility, integrity, equity, timeliness, budget neutrality and cost-effectiveness.

The overriding principle should be that of budget neutrality. Under the current economic conditions in New Brunswick and for the Workers' Compensation Board in particular:

- any changes should not lead to an increase in the cost of operating the board.

However, it is the consultant's contention that:

- expenditures on treatment should be increased so long as there is no additional impact on the net cost of operation of the WCB.

That is, the benefits of additional expenditure on the rehabilitation program can be considered to have been maximized and the interest of the province's workforce best served when a dollar of treatment of expenditure no longer produces an offsetting reduction of a dollar of compensation payments. On the basis of the information obtained from the many persons consulted in this review, we believe there remains considerable latitude to achieve better outcomes for injured workers and that this can be achieved without additional expenditures.

When these principles are considered, the ability of the Workers' Compensation Board to maximize benefits to injured workers, employers and provincial taxpayers declines with any change in the role of the Centre. In time it might be appropriate to include the general population in some of the programs offered at the Centre. Such a change, however, should not occur before it is determined that all the Centre's resources are not required to improve the timeliness of injured workers' rehabilitation. If the Centre is opened up to the general public too early there is also the risk that insufficient attention will be given by government and regional hospitals to the development of needed secondary rehabilitation services.

The draft mission statement of the WRC (not yet approved) states it is .... "to assist injured workers to restore their highest level of independence, vocational productivity and quality of life." It is strongly suggested that this is an appropriate mission statement as it is in the collective best interest of injured workers and their employers.

With the role resolved, however, the benefits of the Centre and its specialized professional resources and programs will only be maximized if it has appropriate clinical leadership, strong linkages with the overall WCB care management process and an effective governance structure. Moreover, the consultants collectively, feel that organizational and operational changes would be much more effective in achieving the Centre's mission and goals than changes in ownership and clientele.

Any specialized role of the Centre should not be continued without the active involvement of the relevant medical specialties - ie. physical medicine and rehabilitation, orthopaedic surgery and neurology. Broadening the role of the medical staff to include managing and improving the effectiveness of the care of injured workers is considered to be the type of change that will increase the attractiveness of the Centre as a place of practice for such specialists. This would involve such activities as the establishment of treatment protocols, training of general practitioners, conducting outcomes-oriented quality assurance and utilization management programs, and arranging purchase of service arrangements from facilities and specialist physicians.

The recent WCB Task Force Report on Organizational Effectiveness appropriately recommends a case management approach to service delivery. The organizational structure proposed is to establish regional managers in the Saint John office with service delivery teams. A second feature of the alternative structure proposed by the Task Force is to establish a Senior Medical Consultant for the Board in the Planning and Research Group. Case management would involve interaction with external service providers and include priorization of admissions to the Centre. The Senior Medical Consultant would develop treatment methodologies in consultation with other medical staff employed by the Board.

While recognizing, as the Task Force does, the importance of improved case management, we feel strongly that effectiveness would be greatly improved if the Centre's clinical staff play major roles in the process and the proposed Regional Managers and Team Leaders have backgrounds in the health professions. We take this position because the fundamental focus of case management should be care management, not financial management.

The goal of care management is to maximize individual patient well-being through the provision of high quality care and the efficient use of resources. High quality of care results from:

- . the use of practice guidelines
- . coordinating care across many providers
- . improving access to care
- . improving continuing education, and providing information to patients

Care management assures the efficient use of resources by:

- . identifying the most appropriate resource setting and use of resources
- . coordinating care to provide care consistent with patient needs, and
- . identifying where care is available.

The general steps in the care management process are: case initiation and data collection: case assessment: and coordination of care and follow-up.

The Centre employs and involves in its treatment programs the range of health professionals that are required to make case/care management effective. We see no advantages in duplicating these resources elsewhere in the organization. Furthermore, involving Centre staff in this way ensures that they will have effective linkages with other providers and that appropriate patients are admitted to the Centre.

The other issue is the role of the Board's Senior Medical Consultant. With the job description developed by the Task Force it is difficult to understand why this position would be located in the Planning and Research Group. Such a position should, in our view, perform a variety of roles in the organization. The primary role would be as medical director at the Centre, and other roles would be as senior medical advisor to the Chairman and the Board and senior medical consultant to the Client Services Division. Such a broad mandate would provide several advantages; it would improve the Centre's linkage with the rest of the organization and it would enhance the attractiveness of the senior medical position and enable the recruitment of a medical leader with strong rehabilitation background.

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6 Operational Reviews

6.1 Centre Wide Issues

The status quo in terms of ownership and access is recommended. A number of changes in operations of the Centre, both internally and within the context of WCB services generally, are suggested.

Individual operational review reports on each department of the WRC follow. In this section, operational issues with a substantial impact on the Centre overall are summarized.

6.1.1 Mission and Goals

A draft mission statement for the Centre has been developed. It or any other which clearly states the focus and philosophy of the Centre, should be approved. The mission and goal statement should also present the broad programs provided by the Centre. Before it can be totally completed, these programs and services have to be defined. The Centre needs to define what its most important functions are, what it is there for.

At the same time, what the Centre's most important functions are now are not necessarily what is most needed. An analysis of claimants' injuries is needed, not just at the Centre but throughout the system. The analysis should provide a profile of the injuries leading to the greatest cost and duration of benefits, and as much as possible, the characteristics associated with them. The Centre should then be used to set clinical standards for the treatment of those injuries and/or to set up programs for them.

The fact that this analysis is not yet completed, however, should not hold back the WRC from defining its current functions.

6.1.2 Organization and Structure

Governing Body

The WRC does have a recently constituted governing body. The importance of the composition and mandate of the governing body to a facility such as the WRC cannot be overestimated. The governing body should be dedicated to the excellence of the centre, act as the link between it and all stakeholders, act as its emissaries as well as bring external perceptions and experiences. The board should be structured to ensure consistency of objectives between the Workers' Rehabilitation Centre and the Workers' Compensation Board.

Thus the mandate and membership of the WRC's governing body should be reviewed. Consideration should be given to inclusion of representatives of employers and injured workers as well as other organizations with whom good communications are important, such as the Family Practice section of the Medical Society or the College of Physicians and Surgeons.

Thought should be given to requiring the members of the governing body to attend an orientation such as the NBHA hospital trustees orientation session. These sessions are currently attended by board representatives of health centres, mental health boards,and nursing homes as well as hospitals, and provide a good understanding of the contribution board members can make.

Once an effective governing body is in place, the Centre's day to day operations should be fairly autonomous, although mechanisms to ensure policy and clerical links need to be in place.

Internal Clinical Organization

As noted above under Mission and Goals, the Centre needs to define its major functions, what it is there for. It then needs to structure itself accordingly. For example, if it finds its major functions were something like assessment and resolution, pain control, back injury, work hardening programs, it should structure its clinical teams around those functions rather than by tasks or activities, such as physiotherapy, occupational therapy, etc. Each program area should incorporate a full range of activities: therapeutic, education, and research.

There was considerable discussion at the project workshop about the pros and cons of program management, which takes the team structure to the level of attributing financial and other resources by program rather than by budget. Some concerns were expressed that this would have a negative effect on staff because of even further reduced clinical diversity as well as loss of professional independence. Points raised by the two external consultants with experience in program management, as well as by some department heads, were that clinical satisfaction increased from being able to relate activities to outcome more clearly, and that a policy of offering rotations of all but the managers between programs alleviated over-specialization.

Internal Administrative Organization

Recommendations re internal administrative organization include:

- Combining of related small departments. There are a number of departments with only two or three staff. Combinations again should be aligned to functions.

- Ensuring that the services of plant and maintenance, and purchasing, which report to head office, are clearly attributed on the Centre budget, as any contracted out service would be, and that there is a mechanism for accountability to the Centre.

- Providing a human resources presence at the Centre. Almost 85% of the Centre's current budget is salaries, and the human resource component is far and away the most important in achieving the Centre's objectives. Consistency between the human resources policy and procedures and the Centre's objectives is difficult to achieve without a physically and organizationally close relationship.

Organization of Centre With Other WCB Services

The Centre should strive to be, and to be regarded as, the arm of the WCB providing standards and education for any clinical activity provided by WCB, whether provided at the Centre or elsewhere. Whereas the operations of the Centre should be more autonomous than at present, clinical links should be closer. This includes links with physicians, links with vocational rehabilitation, and guidance in early intervention.

6.1.3 Quality Issues

Quality issues brought out at the workshop were:

- Research: excellence is only possible with a good understanding of the client profile and its needs. The WRC programs should be structured according to this, but within each program objectives have to be identified and their outcomes measured. The word "research" is often intimidating, but while its goals may be ambitious, it can be undertaken in small practical steps. It is vital that those steps be planned.

- Continuing education: the continuing education priorities of the Centre as a whole need to be identified and a plan mapped out for accomplishing them. Once the Centre's initial program areas are identified, one of the first educational priorities would be directed towards facilitating and carrying out basic research.

6.1.4 Operational Issues

Most of the broad operational issues relate to mission, organization, and quality.

- Early assessment and intervention. While the WRC compares well to other rehabilitation centres in terms of time from injury to admission, it still takes an average of several months. With a clearer understanding of claimant injury profile, it should be possible to better determine which types of claimants most require the full services of the WRC. From the experience of the Bathurst Regionalization project, we know that WRC utilization decreased by nearly 50% when some services were provided locally, with no apparent negative effect on cost and duration of claims. It is reasonable to assume that clients could be triaged more effectively, thus enabling earlier intervention. The WRC clinical staff should take a leadership role in the triaging. A much larger proportion of lost time claimants should be referred to the Centre immediately post injury for short stays of two or three days, where early assessment and therapeutic program planning could take place. The Centre should also be providing guidance to other providers in early assessment and intervention. The possibility of contracting general practitioners in each of the WCB offices to provide early assessment and intervention should be explored.

- Separation of the accommodation and therapeutic programs. There seems to be some inconsistency between the goals of the WRC and the in patient regulations, such as wearing of arm bracelets, administration of medications, monitoring of behaviour. Furthermore, these policies require considerable staff time to implement (See Patient Services Department). It is felt the accommodation and clinical programs should be separated, and injured workers given more responsibility for themselves.

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- Public relations. Better communications are needed with both employers, injured workers' groups, and other providers. This would be assisted through a broad based governing body. Nevertheless public relations goals and activities should be mapped out and resources specifically allocated for them.

- Information system. A clinical information system is badly needed. Whatever information system is selected should be compatible with HMRI rehab systems so that comparisons with other centres can be made.

- Human resources. As documented in the departmental reports, there are some areas where staff levels are questioned and others where more activity should be taking place. Clinical staff levels and responsibilities should be tied to program goals. It is clear that rehabilitation focused clinical strength must be maintained and enhanced, through contracting expertise, continuing education, and employment policies.

6.1.5 Conclusions Centre Wide - Operational Issues

1. The major functions and goals of the Workers' Rehabilitation Centre must be identified and resources structured accordingly. This will require further analysis of claimant injuries, both at the Centre and in the WCB system.

2. Priority should be given to the development and extension of clinical leadership. Once the Centre has developed excellence in defined programs, services may be sold to the public health system or other organizations.

3. A five year implementation plan should be developed mapping out all operational objectives.

6.2 Administration

6.2.1 General Overview

The function of the Administration of the Workers' Rehabilitation Centre is described as "to Manage the workers' Rehabilitation Centre by implementing the policies,plans and directives of the Governing body and applicable relevant legislation". Its principal functions are

- Organization and administration
- Planning
- Management of resources
- Quality Management

The administration has led the development of a Centre wide workplan for the past two years.

Administration is committed to the Centre's obtaining accreditation and has taken several preparatory steps.

6.2.2 Organization and Structure

The Administration reports to the Executive Director, Client Services of the WCB. Some Centre services report to the Executive Director, Corporate Services. A governing body has recently been established whose chairperson is the Executive Director, Client Services, and which is composed of other WCB senior staff.

6.2.3 Budget

Salaries accounted for only 39% of the Administration budget of $1,686,000 in 1991. However, Administration's budget includes several Centre wide costs (e.g. telephone, purchased services) as well as large scale items like depreciation. $6,500 is allocated to education (there is a separate travel budget).

The Centre's overall budget appears to be well managed. It is noted the Centre's 1992 budget is lower than the previous year's.

6.2.4 Staffing

Staffing includes an Administrator, Assistant Administrator, Director of Therapeutic Services (not filled), Quality Assurance/Risk Manager, Support Services Supervisor, and five clerical staff. The Medical Director is attributed to the Medical Department staff.

6.2.5 Workload

It is difficult to assess the administrative workload. The five clerical staff cover a number of the small departments in the Centre. The Director of Therapeutic Services position is unfilled and currently there is an interim position available to prepare for accreditation. Billings for WRC services are under patient services. Since the administration is under the direction of the Executive Director for Client Services,and since several Centre services are not accountable directly to the Centre at all, administrative responsibilities are in some ways reduced. However, the structure may increase workload in terms of communication complexities.

6.2.6 Recommendations

Recommendations regarding Administrative Services usually implicate more than one department and often the Centre as a whole.

1. *The Administrative Services' mission statement should relate to the mission of the Workers' Rehabilitation Centre.*

2. *The Administration needs an effective governing body for support, accountability and guidance. It then should be encouraged, indeed requested, to take initiative and demonstrate leadership in achieving the Centre's objectives. Position descriptions of the senior management team, in particular that of the administrator, should be formulated accordingly.*

3. *The Administration needs to have some management responsibility for Human Resources at the Centre.*

4. *Services provided by head office such as plant and purchasing should show clearly on the Centre's budget, and have some mechanism for accountability to the Centre, as with any contracted service.*

5. *Administration must take leadership in:*

    - *Including outcome indicators, monitoring mechanisms, and time frames in its annual workplan*
    - *Developing a Centre wide orientation program (on the 1992 workplan)*
    - *Developing Centre wide continuing education priorities and a strategy for meeting them*
    - *Developing a public relations plan and structure*

- *Promoting and structuring research, beginning with ensuring that information gathering mechanisms and structure (e.g. systems) are in place*
- *Developing a team/program orientation to the major functions of the Centre*
- *Facilitating separation of the accommodation and therapeutic services of the Centre.*

6. *Therapy is what the WRC is about and it is inappropriate that the position of Director of Therapeutic Services is unfilled. Yet the role will depend on the direction the WCB and the Centre decide the Centre will take. The administration with the WCB should initiate a review of the Centre's functions and its total leadership resources, identify the greatest gaps, and plan the positions accordingly. This activity should be a top priority.*

6.3 Medical Services

6.3.1 Overview

The mission of the Medical Services Department is to provide medical services consistent with the goals and objectives of the Workers' Rehabilitation Centre.

Major functions are:

- Assessment; review of documentation, interviewing and examining, recording
- Treatment; provision of primary and secondary care, and health promotion
- Discharge planning; continuity with family physician, specialist, Bathurst and head offices
- Administration

Organizationally, the Medical Services is responsible to be Administrator of the Workers' Rehabilitation Centre.

With the exception of the Medical Director and the manager of the Pain Control Unit, the medical staff offices are located together with Nursing in the Nursing Care Unit. Physical facilities appear satisfactory.

Medical Services hours are from 0800 to 1700 hours Monday to Friday, with on call coverage the rest of the time.

A recent audit of specialists in the province to whom injured workers are referred found generally high levels of satisfaction regarding communication and services.

6.3.2 Budget

The budget for Medical Services excluding the Manager of the Pain Control Unit was about $941,000 in 1991, about 15% of the Centre's budget. Salaries accounted for 96% of the budget.

6.3.3 Workload

	1988	1989	1990	1991
Admissions		1,602	2,294	2,374
Inpatient	1,604	1,601	922	797
Day program		706	663	824
Outpatient			709	753

Admissions appear to be allocated to individual physicians primarily on the basis of current workload, with the exception of the Pain Control Unit. Language can also be a factor.

6.3.4 Staffing

There are eight full time physicians, including the Medical Director and Pain Control Unit Manager. Currently, there are no sessional appointments.

6.3.5 Recommendations

1. *The medical staff should take a lead in organizing and establishing a program structure in the Workers' Rehabilitation Centre.*

2. *The medical staff should work with the administration to develop the operational autonomy of the Centre, to include enhanced budget controls, improved access to the Rehab Centre on a timely basis, and the development of correct linkages with the Bathurst unit and other outside treatment units.*

3. *The medical staff should develop a formal and direct communication with the Board, for example establishing regular meetings.*

4. *The medical staff should initiate a review and update and formalize an orientation process for new staff which would likely include a significant amount of time spent at Workers' Compensation Board headquarters.*

5. *The medical staff should take a lead role with administration in obtaining accreditation.*

6. *The medical staff should take a lead role in the establishment and promotion of education and research at the Workers' Rehabilitation Centre.*

7. *The medical staff must develop Quality Management indicators and explore Continuous Quality Improvement.*

8. *The medical staff should review the issue of "self medication" which would seem to be most appropriate for the clientele being serviced.*

9. *The medical staff, in concert with the appropriate individuals, should contribute to the review of the role of Recreology and Nursing (see Recreology and Nursing Operational Reviews).*

6.4 Psychology

6.4.1 Overview

The Psychology department describes its' statement of purpose as "to provide effective psychological services to patients in order to assist them to restore their highest level of independence, vocational productivity, and quality of life."

Its major functions are:

- Psychological assessments; which may or may not employ a numerical scale
- Treatment and evaluation;this includes counselling and psychotherapy
- Education; to the injured workers, on topics such as stress management, assertiveness, communication, pain-behaviour relationships
- Statistics and data collection;clinical and non clinical

The Psychology Department at WRC is a consulting service. All clients seen by Psychology undergo some form of assessment. About two-thirds of those assessments are psychovocational in focus and evaluate aptitudes, interests and personality features with a view to making recommendations as to alternative vocational options. About one-third of these assessments are clinical personality assessments to diagnose the possible presence of significant psychological problems arising from the injury and its sequelae, such as post traumatic stress disorder, anxiety or depression. Only about 1% are neuropsychological assessments, which is low in a rehabilitation context generally, but understandable in that WRC has no head injury clinic. About 25% of the clients who are assessed in Psychology go on to receive counselling or psychotherapy, for an average of about 6-8 sessions; if necessary, these clients are then referred to a clinical psychologist in the community for continued treatment following their discharge from WRC.

In addition, Psychology is intimately involved with the Pain Control Unit, providing both personality and psychovocational assessments on all clients, as well as group therapy (about 6 sessions per week). The group therapy sessions focus on issues such as pain behaviour, financial concerns, medications, anger management, coping skills and employment counselling.

Quality management is provided by sending evaluation questionnaires to referring sources and injured worker clients on a monthly basis, with a report on these being forwarded to the management committee every three months. Scientific research has not been part of the department's activities since the mid-80's. Staff development activities have been mostly in-house, with the exception of a couple of outside courses, of peripheral relevance.

The Psychology Department reports to the Director of Therapeutic Services, which is staffed.

The department operates from 0800 to 1700 hours Monday to Friday.

6.4.2 Budget

The 1991 annual budget for Psychology was 232,000, representing about 4% of the Centre's budget. The 1991 budget was almost 20% lower than 1990.

6.4.3 Workload

Workload statistics are shown below.

Our consultant found that in terms of the actual amount of work done (number of assessments, etc.), the Psychology Department is carrying more than is typical for institutional settings. When one factors in the administrative requirements (e.g., meetings, etc.), it is difficult to see how the Department can do all its clinical work within 35 hours per week. Moreover, the quality of the work appears to meet the usual standards. The tests employed were found to be entirely appropriate for the client population. The Department's Policy and Procedure Manual was pertinent and up-to-date. For the purpose of this evaluation, a sample of files containing client assessments was reviewed, and the quality of work was found to easily match that of psychological assessments in other institutional settings. Data pertaining to the timeliness of psychological intervention was also reviewed, and here also the Psychology staff appeared to be doing a superb job, in some cases actually seeing a client on the same day that the referral reached the Department. Furthermore, a review of Continuous Quality Improvement questionnaire summaries indicated that both referral sources and injured workers were very happy with the service provided. Discussion with the Manager of Psychology as to the nature of therapeutic intervention strategies for both individual and group therapy revealed that these are fully in keeping with the literature and with what is done elsewhere.

6.4.4 Staffing

The Psychology department staffing consists of two psychologists and two psychometrists.

6.4.5 Recommendations

1. *Earlier identification of clients with likely psychotraumatic components would be both more effective therapeutically and more cost-effective. Within WRC, it takes 3 to 4 weeks for physicians to identify patients likely to require psychological assessment and intervention.*

2. *The role of the Psychology Department needs better definition. Because of the demands on Psychology's strained resources, there is some conflict between the needs for psychological assessments (including psychovocational assessments) and the needs for therapeutic intervention. A clearer sense of mission for WRC would optimize Psychology's contributions.*

3. *The Department is understaffed. The Department is overworked by the standards of similar institutions. If the client population were to increase (e.g., by admitting Medicare patients), or if the Department were to better fulfil some of the other functions that it should fulfil (see point 4), it would be stressed beyond the breaking point.*

4. *Scientific research should become part of the Department's mission. Not only do psychologists have expertise in research methodology by virtue of their training, but the client population at WRC begs for scientific investigations, and WRC is in a unique position to carry out such research (which would also provide considerable visibility). Psychology should become involved in its own scientific investigations and, in addition, it could serve as a resource of methodological and statistical expertise for research carried out by other departments at WRC. This would require some increase in staff.*

5. *To enhance Quality Management, some formal mechanism of peer review or file audit should be implemented. This could be done using departmental staff if the Department should grow in size, or psychologists from sister institutions across the country could provide a yearly audit of randomly selected files.*

6. *An institutional commitment to staff education through conferences and courses is imperative, even if these are offered outside of New Brunswick. Moreover, sponsored programs of study should be compatible with the mission statements for WRC and its Psychology Department.*

6.5 Physiotherapy

6.5.1 Overview

The physiotherapy department reported its mission as "to provide physical therapy services to all referred injured workers in order to restore their highest level of physical independence."

Its major functions are:

- Patient care; this includes assessment and treatment
- Patient services; provision of outpatient service or supplies, such as canes, packs, weights, the TENS program
- Healthy and safe environment; ensuring maintenance of equipment, proper body mechanics,
- Education; staff education and professional development, student education

The department reports to the Director of Therapeutic Services, a position which is currently unfilled.

Physiotherapy facilities include a gym, recreation room, pool, and offices. Equipment and facilities are in generally good condition.

The department operates from 0800 to 1630 hours Monday to Fridays.

6.5.2 Budget

The 1991 budget for physiotherapy was approximately $840,000, accounting for about 13% of the Centre's budget. Salaries accounted for 90% of the budget.

6.5.3 Workload

Workload information is presented below.

Workload in terms of attendances experienced a decline of about 10% in 1991 over the previous year. Total admissions for physiotherapy decreased about 6%.

6.5.4 Staffing

There are 19 staff in the physiotherapy department. This includes the manager who has been on temporary assignment to administration most of 1991. The acting manager has thus been spending most of her time in administrative tasks.

Employee turnover is relatively high. Most of the physiotherapists work only for the two years required by their bursary program, thus constant orientation is required. Staff morale is reported as low, and this is seen as due to slowness of change and lack of staff input into the work environment.

6.5.5 Recommendations

The recommendations of the Physiotherapy consultant were:

1. *The activities of Physiotherapy be coordinated with other disciplines and departments. Physiotherapy should be working with Claims and Medical Services to expedite referral to the WRC. If inability to return to work is identified during the Physiotherapy assessment or at any point during the treatment program, Vocational Rehabilitation should intervene.*

2. *There be an increase in communication with community based physiotherapists to ensure the most appropriate referral of the injured workers - either to the WRC or to a private practice dependent upon the clients' needs.*

3. *Integration of health care patients into the WRC be considered provided there is an associated impact analysis completed.*

4. *Workload be measured accurately to ensure that department management can quantitatively justify the retention of the present staff complement and support requests for staff increases with any increase to the present caseload.*

It is felt that implementation of these recommendations could be expected to

- *Accelerate initial intervention*
- *Increase return to work or retraining rates*
- *Increase staff morale*

6.6 Occupational Therapy

6.6.1 Overview

The mission of the Occupational Therapy department is described as " to promote the injured workers' functional independence in work, leisure, and activities of daily living utilizing effective Occupational Therapy assessment, evaluation and intervention techniques."

Its major functions are;

- Functional assessment; physical, psychosocial and sensory assessment of all injured workers admitted; when required, Activities of Daily Living, On the Job, and/or home assessments may be done.
- Intervention; Work hardening, general conditioning, work simulation, work tolerance development
- Patient education; lifting and transfers, back care, relaxation, stress management
- Evaluation; all individual injured workers as well as specialized work evaluations.
- Consultation; externally to regional offices and Vocational Rehabilitation
- Clinical fieldwork; accredited training facility for Occupational Therapy students.
- Education; continuing and professional education
- Administration

Organizationally, the Occupational Therapy department reports to the Director of Therapeutic Services, an unfilled position.

The department operates from 0830 to 1630 hours, Monday to Friday. Physical facilities include work simulation areas, plant and carpentry shops, back education room, rooms for transfer class and relaxation class, assessment room and office space. Facilities and equipment are in good condition.

The department is in the midst of implementing a work hardening program which is to change the focus of the department from crafts to work stations.

6.6.2 Budget

The 1991 annual budget of the Occupational Therapy department was about $960,000 or about 15% of the Centre's budget. Salaries accounted for 87% of the budget.

6.6.3 Workload

Workload indicators are presented below.

Workload has shown a steady increase. Currently a workload measurement system is not in place.

6.6.4 Staffing

Total staff complement is 18. Turnover is considered a problem, and cancellation of the bursary program is a major concern. There is a need for a greater proportion of auxiliary staff to supervise maintenance programs. Implementation of a workload management system and the work hardening program should promote role definition and staff efficiency.

6.6.5 Recommendations

It is recommended that:

1. *The activities of Occupational Therapy be coordinated with other departments. Occupational Therapy should be working with claims and Medical Services to expedite referral to the WRC.*

2. *The role of Vocational Rehabilitation and its relationship with Occupational Therapy be more clearly defined. There is a need for interaction between the two disciplines at the time of initial assessment by Occupational Therapy if warranted or at any time during Occupational Therapy treatment when a need for job retraining may be identified.*

3. *Integration of health care patients into the WRC should be considered provided there is an associated impact analysis completed.*

4. *Workload must be measured accurately to ensure that department management can quantitatively justify the retention of the present staff complement and support requests for staff increases with any increase to the present caseload.*

6.7 Pain Control Unit

6.7.1 Overview

The mission of the Pain Control Unit is "to provide effective interdisciplinary services to referred patients suffering from chronic pain in order to achieve their highest level of independence, vocational productivity, and quality of life.

Major functions of the unit are:

- Pre admission screening
- Interdisciplinary treatment process; education, physical activity levels, work tolerance evaluation, relaxation classes, group therapy,planning post discharge management
- Spouse's program
- Post discharge follow up

Organisationally, the interdisciplinary members of the Pain Control Unit appear to report to the Unit Manager, who reports to the medical Director of the Centre.

The unit is housed in a designated area of the Centre. Physical facility and equipment are in good condition.

The Pain Control Unit operates from 0800 to 1630 hours Monday to Friday, with emergency physician coverage at other times.

6.7.2 Budget

The 1991 annual budget of the unit was $240,600, or about 4% of the Centre's budget. The budget does not include salaries of the occupational therapist, physiotherapist, psychologist, or dietician members of the interdisciplinary team, or continuing education allocations for them. Salaries accounted for 96% of the budget.

6.7.3 Workload

Workload indicators are presented below. The number of admissions per year and length of stay are constant, determined by the program itself. Number of screenings may fluctuate, depending on referrals.

6.7.4 Staffing

There are three full time staff on the Pain Control Unit budget; the manager, nurse, and remedial gymnast. In addition, a psychologist, occupational therapist, physiotherapist, and dietician are members of the team.

6.7.5 Recommendations

1. *The Pain Control Unit should be maintained and enhanced.*

2. *The Unit should define its role as a program within the Workers' Rehabilitation Centre.*

1. *The roles of team members should be reviewed, particularly the nursing component.*

4. *The Unit's research role needs to be developed.*

5. *The Pain Control Unit should establish linkages with other pain units around the country.*

6. *With research and linkages established, there is great potential for the unit to package and "sell" services to the civilian population in the future.*

6.8 Prosthetics and Orthotics

6.8.1 Overview

The mission of the Prosthetics and Orthotics Department is stated as "to deliver a concerned and effective rehabilitation service to injured workers. Through provision of prosthetic and orthotic devices, it enables workers to restore their highest level of independence, vocational productivity, and quality of life."

Major functions of the department are;

- Prosthetic and orthotic service to injured workers; assessment, fittings, repairs, education, charting
- Prosthetic and orthotic care to injured workers; outpatient and extramural care through phone calls, written referrals regarding receipt, repair, return and advice re components
- Inventory control, costing, and billing

The department reports organisationally to the Director of Therapeutic Services, a position which is not filled.

The Prosthetics and Orthotics facility is in good condition and well equipped.

The department operates from 0830 to 1700 hours Monday to Friday.
Quality management audits included response time, workload indicators, accidents, and client satisfaction. Audits, particularly for client satisfaction, were positive.

6.8.2 Budget

The 1991 budget for Prosthetics and Orthotics was about $133,000 or 2% of the Centre's budget. Salaries accounted for about 96% of the budget.

The consultants carried out a cost comparison between the Prosthetics and Orthotics department and two private suppliers for three services provided by the department and found costs compared favourably. This is attached in Appendix .

6.8.3 Workload

Workload indicators are presented below.

Workload has been fairly stable, with a very moderate increase.

6.8.4 Staffing

There are four staff in the department including the clerk/typist.

6.8.5 Recommendations

1. The Prosthetics and Orthotics department should continue with its present mandate and role.

2. A computerised system of inventory control should be implemented to improve efficiency.

3. The issue of supplying services to civilians should be explored but likely would only be a viable alternative if there were long waiting lists for civilian service providers.

4. The patient information system needs to be improved.

5. The WCB should review the issue of monitoring quality of work by outside agencies. WCB should establish standards for outside manufacturers from whom it purchases services, including the need for certified prosthetists and orthotists, and accreditation of the facility.

6.9 Nursing

6.9.1 Overview

Nursing has defined its mission as :

> "To provide effective 24 hour nursing care and services to meet the physical, emotional and social needs of the patients admitted to the Workers' Rehabilitation Centre".

Its principal functions are:

- Assessment and planning
- Treatment and evaluation
- Clinical chart
- Health and safety

The nursing unit is located with the suite of physicians' offices for the WRC. It includes 13 beds (three four bed rooms and a private). These are used by patients who are not well, need monitoring, or need to be separated from other patients in the main accommodation areas. A sampling of the nursing unit book indicated occupancy at between 40 to 50%.

Nursing sees all in patients and full day patients on admission (about 25 per week). Time from patient's arrival in Nursing until completion of the admission was recently audited at 20 minutes. The admission includes measuring and recording vital signs.

Nursing usually but not always will see the injured worker again at some point before discharge. Its role in any of the therapeutic programs of the Centre is not specifically defined.

Nursing attends clinical team meetings and rounds, but as an interdisciplinary care plan has not yet been implemented (is planned), it is difficult to determine its contribution to clinical objectives.

Nursing can and does provide emotional support, particularly since it is available on a 24 hour basis, but it is nevertheless not the discipline to which patients relate most closely, according to the group we met with.

Nursing administers patient medications to all inpatients if the medication is one carried by the Centre. It provides emergency assessments (CPR and First Aid) when needed and teaches CPR and First Aid to the other staff.

Because nursing is available 24 hours, it covers reception after 1630 hours. For the same reason it is responsible for all incident reports outside the Day shift, although many are referred elsewhere the next morning.

In terms of the duties of the day, evening, and night nurse, they appear to be much more clerical and administrative than clinical or therapeutic in description.

Nursing reports to the Director of Therapeutic services, a position that is currently not filled.

6.9.2 Budget

The 1991 nursing budget of approximately $510,000 accounts for about 7% of the Centre's budget. Salaries account for 97% of the nursing budget. The education allowance in the 1991 budget was $770.

6.9.3 Staffing

There are 12 nursing staff, including the manager and clerk (the nurse in the Pain Control Unit is on the PCU's Budget).

Staffing is usually 3 RN's and 1 - 2 orderlies on days, an RN and two orderlies on evenings, and an RN plus one orderly at night. Casual staff are available for replacement or the occasional weekend that the nursing unit is kept open (about three times a year).

6.9.4 Workload

Traditional nursing workload measurement systems would not seem to be applicable since they relate to patient care hours, of which there are few.

Activities of nursing staff were logged for two days of two weeks for this review. Nursing staff, exclusive of the nurse manager spent an average of 83% of their time in activities with direct or indirect patient contact.

Nursing is planning to identify and implement an appropriate nursing management information system.

6.9.5 Recommendations

1. *The role of nursing in the Centre's rehabilitative programs must be clearly defined. Potentially much more active roles exist, such as patient counselling, acting as primary liaison, teaching of health and safety, but they must be tied to therapeutic objectives.*

2. *Nursing needs support and assistance in reviewing its role. Either the position of Director of Therapeutic Services should be filled and mandated to provide this assistance, or an interim person found.*

3. *Nursing must develop continuing education priorities related to its role in rehabilitation and be allocated a continuing education budget which allows it to implement these priorities. A general nursing background needs to be supplemented for nursing to be most effective in rehabilitation.*

4. *If the role does not become more therapeutically focused, a review of required staff qualifications in relation to duties is indicated.*

Applied Management

6.10 Recreation

6.10.1 Overview

The mission of the Recreation Department is "to provide balanced leisure time activities and programs that encourage individual residents to meet their leisure needs". The department's major functions are described as:

- Recreation activities
- Special program/service (individual patients)
- Promotion
- Health and safety

Recreation sites include the games room, the theatre, library, patient lounges, the Centre's outside grounds and, to some extent, the gym. Many programs take place in the cafeteria, a library book loan service is also available.

Recreation staff are available from 1400 to 2200 hours, Monday to Friday and 0830 to 1630 on Fridays. Staff provide an orientation at admission and explain what is available for in patients and/or commuters.

In the past patients were asked to complete a questionnaire indicating their leisure interests. More recently, it was decided to establish a patient committee to advise on leisure programming.

Although the membership changes constantly due to patient turnover, this seems to work quite well and provides a mechanism for more active patient participation. However, only residents are members (not commuters).

Quality assurance audits include resident satisfaction questionnaires, which are positive.

6.10.2 Budget

89% of the 1991 budget of about $87,000 is for salaries. The continuing education allocation was $300. The department's budget represents slightly more than 1% of the Centre's budget.

6.10.3 Staffing

There are two full time recreation staff.

6.10.4 Workload

	1988	1989	1990	1991	1992 (projected)
Patient days (residents only)	30,352	27,491	26,069	21,919	
Participants	22,892	16,418	12,869	11,838	
%	75.4	59.7	49.3	54	60

The participation rate decreased and then stabilised. Recreation staff attribute this to the opening of a bar and restaurant across the road.

The recreation supervisor reports 65% of her time is spent on administration.

6.10.5 Operational Concerns

The role of recreation to the goals of the Centre is either unclear or unrecognised. The department is considered to provide a leisure rather than therapeutic program. The recreologist supervisor does not have the therapeutic qualification usually required in this province. Yet recreation therapy is important in some rehabilitative programs.

Even in terms of a leisure program, the department seems somewhat underutilized. Leisure recreation is not available to day patients (commuters) who are becoming an ever more important component of the Centre's clientele. This is difficult to understand, since development of leisure interests certainly reinforces a rehabilitative philosophy.

For the residents, more use could be made of the facilities at the Centre than is allowed. In particular, the pool does not appear to be utilised anywhere near capacity and the residents have indicated they would like more access to it.

6.10.6 Recommendations

1. *As the major therapeutic programs of the Workers' Rehabilitation Centre become identified and further developed, the role of recreation in each of them should be reviewed.*

2. *Leisure recreation should be encouraged in both resident and commuter clients.*

3. *If the department continues as an exclusively leisure program, it should be integrated administratively with other direct client services. If some aspects become therapeutic, consideration should be given to how those aspects can be integrated with the appropriate program.*

6.11 Patient Services

6.11.1 Overview

The mission of the Patient Services Department is "to provide compassionate counselling to patients, effective and efficient non clinical information, and accounting and support services to the Workers' Rehabilitation Centre".

Its functions thus are:

- Counselling; patient orientation, discipline, and education
- Support; patient travel expenses, petty cash funds, passes, tours for external visitors
- Non clinical information; claims information, discharges, patient attendance/absenteeism
- Accounting; billing for WRC services, ledger keeping, audits

Patient Services Department is open from 0800 to 1700 hours Monday to Friday.

Patients are free to drop by at any time. The department generally has an open door policy.

The department is responsible for reviewing patient incidents and taking appropriate action.

6.11.2 Organization and Structure

The department reports to the Assistant Administrator of the centre.

6.11.3 Budget

Of the department's 1991 budget of $116,000. 98.6% was for salaries. $1235 was available for continuing education.

6.11.4 Staffing

Department staff includes a supervisor, an accounting clerk/typist and a patient services clerk.

6.11.5 Workload

Workload is particularly associated with numbers of admissions and discharges, numbers of incidents, and absenteeism.

	1988	1989	1990	1991
Admissions		1601	2294	2374
Inpatient	1604	1601	922	797
Day Programs		706	663	824
Outpatient			709	753
Discharges	1627	1583	2315	2367

In 1985 there were 85 incident reports.

6.11.6 Operational issues

Travel Allowances and Absenteeism

Considerable time is spent allocating travel allowances which are given to all patients whether resident or commuters. Then considerable time is spent monitoring whether patients have attended their programs - checking log books,then checking whether patients were actually there but forgot to sign, etc. We question the policy of providing travel allowance to commuters who would after all be travelling to work if employed, and we question the amount of time put into determining a patient's participation in his program, which would not take place if treatment were being received elsewhere.

Patients carry cards with their treatment schedules on them. Perhaps a means of punching or stamping these could be developed to resolve the issue of whether travel allowances should be given. It would also relieve the need for so many appointment reminders over the P.A. system, since it would be up to the injured workers themselves to show up.

Disciplining

Most patient incidents relate to violations of rules, and most involve residents. Counselling, referring, and disciplining for these incidents is very time consuming and we question its productivity in achieving the rehabilitative objectives of the Centre.

Orientation

Patient orientation is usually provided on the Monday or Tuesday following admission, but can be as late as Wednesday. The patient group noted that they have to know the rules from the day of admission (Sunday) until then. Also patients do not currently receive any information before admission (a document is in progress)

Organization and Structure

The functions of the department are very diverse, yet it is a small department. Perhaps its' functions can be aligned with related departments.

Public Relations

The Patient Services Department provides tours and information to employers and other external groups on request. Public relations, however, is not a specifically designated activity.

Staff Availability

One of the staff is on the union executive and is absent quite often for union business which is hard on the department.

Notice of Discharges

If Medical Department does not send Notice of Discharge to Patient Services (which advises Admissions, Medical Records, and WCB head office) over billing and over payment of travel may result.

6.11.7 Recommendations

1. *A review of the WCB travel allowance policies should be requested.*

2. *Means of reducing behaviour and absenteeism monitoring should be identified and piloted.*

3. *Residents and commuters should be provided with orientation material pre admission and/or immediately upon admission. The Patient Committee (which perhaps could be termed the Resident Committee) appears to be a viable means of providing admission orientation.*

4. *Realignment of the functions of the department within the Centre should take place. For example, combining the Accounting or financial functions with administration would be logical and remove the need for transporting cash back and forth to the safe in administration. Combining orientation and patient counselling with admissions would facilitate pre admission orientation. Combining with Health Records would facilitate records keeping (Notice of Discharge in a health facility should be sent immediately to Health Records).*

5. *Public relations activities should be specifically planned, and resources allocated.*

6. *If it is policy to allow employees paid time for union business, than relief monies (and staff) should be allocated.*

6.12 Dietary Department

6.12.1 Overview

The purpose of the Dietary Department is to provide nutritional care and services according to the therapeutic needs of the injured workers and to visitors, staff and the community as appropriate. The major responsibilities for this department are:

- Catering to meetings and special meals for Administration and staff (has been increasing)
- Cafeteria services for patients and staff

  0730 - 0830 Breakfast

  1130 - 1300 Lunch

  1620 - 1730 Supper

  0940 - 1030 Coffee Break

  1445 - 1530 Coffee Break
- Inpatient meal distribution to floor (very limited)
- Deliver some trays to patients in cafeteria
- Meal production
- Cleaning of kitchen, dining and servery area
- Storage of food and supplies
- Department requisitioning for purchasing
- Budget preparation
- Staff in-service
- Staff recruiting/scheduling
- Quality assurance program/risk management

Clinical Nutrition Services

- Menu planning
- Nutrition programs planning and implementation
- Nutrition promotion
- Nutrition counselling
- Food product review
- Quality assurance
- Documentation of patient progress.

A limited vending service is provided by outsiders.

During the course of the review the following issues were identified.

- Food storage shelving needs to be replaced in the walk-in coolers
- The equipment is aging which could result in replacement costs or equipment repair costs
- Special functions have increased significantly during the past year which has added to workload
- Layout of department is good except perhaps location of dishwashing area
- The servery area is single file which creates long queues at times
- It is reported that menu could be more health oriented; efforts are being made to closely meet the Nutrition Recommendations for Canadians
- The paid hours for WCB absence was 3,185 hours in 1991, equivalent to 2.0 FTE
- There were 159 sick days in 1991, averaging 12.2 days per person. This is excessive, and should be examined (two people were on long term sickness).

6.12.2 Workload

	1988	1989	1990	1991
Patient Meals	121,050	124,836	126,114	122,123
Staff Meals	12,413	11,322	11,143	12,663
Guest Meals	2,558	2,271	1,690	2,123
Meals on Wheels	1,801	1,369	1,132	985
Total Meals Served	137,822	139,798	140,079	137,894

	Patient Meals	Patient Days	Divide 250 Avg/day (meals)
Inpatient	122,123	40,707	488
Staff	12,663	4,221	51
Guests	2,123	707	8
M.O.W.	985	328	4
Total	137,894	45,963	551

Percentage Breakdown by Meal (Average Day)

Breakfast	143	26 %
Lunch	286	52 %
Supper	122	22 %

Note: There is occasional need to have service available on weekends, but never exceeding four people.

6.12.3 Financial Data

	1991 Budget		1991[1] Actual 11 months to end of November	
Labour	$433,113	70.6%	$424,561	75.7%
Education	1,640	0.2%	121	--
Minor Equipment	11,566[2]	1.9%	616[3]	--
Supplies (non-edible)	10,400	1.6%	8,339	1.5%
Equipment Maintenance and Repair	3,150	0.5%	1,519	0.3%
Wearing Apparel	600	--	670	0.1%
Food	153,000	25.2%	125,206	22.3%
Total	$613,469		$561,032	
Cash Revenue	24,050		22,000[1]	
Net Department Cost	589,419		539,032	
Net Department Cost/Meal Day	$12.82		$12.80	
Food Cost per Meal Day	$3.32		$2.97	
Labour Cost per Meal Day	$9.42		$10.08	
Gross Cost per Meal Day	$13.34		$13.32	

1 Estimate

2 Includes major capital equipment

3 Just minor capital equipment

Labour cost should be in the range of $6.00 per meal day, so labour costs are high. Meal costs are appropriate.

6.12.4 Staffing

FTE by Classification

POSITION	Classification	Language	Budget FTE 91	Current FTE 91	Projected FTE 92	% Time Spent On: Direct Work	% Time Spent On: Admin.	% Time Spent On: Educ./ Training
Manager of Dietary Services	Dietitian	Bilingual	1	1	1	40	50	10
Food Service Supervisor		English	1	1	1	5	90	5
Cooks	Level II	English	1	1	1	90	10	
	Level I	English	2	2	2	100		
Assistant Cooks		English	2	2	2	100		
Food Service Assistants		Bilingual English	2 5	2 4	2 5	100		
Total			14	13	14			

Staff Schedule

Cook II and Cook I's	2 work 0600/1300 1 works 0915/1715	Every 3rd week a cook works the late shift
Assistant Cooks	1 works 0600/1300 1 works 0915/1715	1st week assistant cook is on early 2nd week he/she is on late shift
Dietary Service Assistant	3 work 0700/1500 3 work 0945/1745	1st week - 3 work early shift 2nd week - same 3 work late shift
Food Service Supervisor	0730/1530 daily	
Dietitian	0900/1530 daily (casual)	

Statistical Data - Paid Hours

Items Required	1991
Total Paid Hours	18,655
Less Paid Sick Hours	1,113
Paid Vacation/Stat Hours	2,373
Paid WCB Hours	3,185
Equals: Paid Hours Worked	11,984
No. FTE's in Department (Budget/Approved)	13.0

Non-productive factor on paid hours is 35.8% which is high.
Average sick days per employee is 12.2 days which is high.

Comment

- The labour costs per meal day are too high. This is a cafeteria service, not an inpatient type service.
- The recovery of revenues in the cafeteria should be higher. Currently, only the food cost is recovered, not labour or overheads.
- Food cost is satisfactory.

6.12.5 Recommendations

1. *There should be full recovery of all costs relative to cafeteria pricing for everyone.*
2. *We suggest that there should be a 10% profit margin for cafeteria prices.*
3. *Food prices should be reviewed on an ongoing basis but at least annually.*

4. *The staffing complement should be reduced. The following complement and distribution is suggested, subject to refinement.*

	FTE	*Schedule*
Clinical Dietitian	*0.5*	*M & W 8 - 4, F 10-1*
Food Service Supervisor	*1.0*	*M - F - 7:30 - 3:30*
Cook II	*1.0*	*M - F - 7:30 - 3:30*
Cook I	*2.0*	*M - F - 7:30 - 3:30*
		M - F - 10:00 - 6:00
Food Service Workers	*4.0*	*2 M - F - 7:00 - 3:00*
		2 M - F - 10:00 - 6:00
Total	***8.5***	

5. *Weekend food, if required, should be ordered in.*

6. *Clinical dietician needs should be reviewed in relation to each of the Centre's program areas as these are identified and developed.*

6.13 Admitting

6.13.1 Overview

The Admitting Department opens 0800 - 1630 hours, Monday to Friday, with a one and half hour lunch break. There are four prime functions of the Admitting Department, namely:

- Admitting and Discharging Patients (20-25 per week)
- Scheduling
- Bed Control and Census
- Statistics

The admissions for each admission is done in approximately 10 minutes, with the majority of the admissions on Monday and Tuesday. Arrivals on Sunday evening are admitted Monday morning. The staff prepare addressograph card, I.D. bracelet, notice of admission and information is verified in the WCB computer system. Scheduling is done two weeks ahead during Wednesdays - Fridays. A daily census is kept as are certain other statistics.

The management is provided by Donna Stephens from Administration. There was a full-time Supervisor previously, a position that remains vacant.

One factor affecting productivity is the poor computerized admitting system which duplicates work and it is reported to not be accurate at times. It is understood that WCC is planning to implement a new computer system which should reduce the workload in Admitting.

Some of the external problems are that Admitting is not notified in a timely manner of discharge. Time is also spent on verifying patients attempting to postpone and to avoid appointments at the Centre.

6.13.2 Workload

	1987	1988	1989	1990	1991
Beds	126	126	130	130	118
Inpatient Days	24,950	26,269	22,845	20,886	19,192
No. of Admissions	1,065	1,139	1,016	922	792
Outpatient Visits	1,062	1,115	1,291	1,370	1,577
No. of Patients	2,127	2,254	2,307	2,292	2,374
Average Stay (days)	23.4	23.1	22.5	22.7	24.2

Since 1987, the number of admissions have decreased by 26%, patient days by 23%, but outpatient visits have increased by 48%, showing a trend away from inpatients.

6.13.3 Staffing

Present Staffing

Admitting Clerk	1.0 FTE
Floater	0.6
Total	1.6 FTE

Ratio - 1.06 worked hours per admission or outpatient visit.

Comments

1 The main peak loads occur at times during the admission process at the beginning of the week, and some help is required then.

2 These are peak loads during the discharging of patients towards the end of the week.

3 Although considerable time is spent in scheduling during the latter part of the week, it is our view that there could be slack times, so it would be an advantage to combine this department with another. There appears to be a close relationship to the Patient Services Department, so possibly, these two could be combined in some way. One suggestion is to relocate the billing clerk from Patient Services to admitting.

4 Admissions takes about 10 minutes per admission, which is about four hours work for 24 admissions performed each week.

5 The introduction of a computer system will reduce the workload in Admitting.

6.13.4 Recommendations

Proposed Staffing

Admitting Clerk	*1* . *1* *FTE*

We are assuming that the new computer system will save time to the extent that one person can handle all admissions and outpatient visits, with some assistance during peak loads from the billing clerk or float pool.

The Department should continue to be supervised either by Administration or by Patient Services, depending on the final proposed organization chart for WRC.

The vacant Admitting Supervisors position should be eliminated.

6.14 Health Records

6.14.1 Overview

The purpose of the Health Records Department is to manage patient information and maintain a confidential record for the care of every patient admitted to the Workers' Rehabilitation Centre.

This department operates from 0800 to 1700 hours, Monday to Friday with an actual staff of 7.0 FTE's. The department is responsible for chart processing, filing, coding and abstracting, audits and transcription services. The department head is also responsible for the library.

The prime functions of the department are:

- Preparing and filing of Clinical Records
- Transcription
- Coding and Statistics
- Patient Information
- Library.

The health record is a unit, integrated record. Unit numbers were first assigned in January 1990. About 2,800 charts are filed by terminal digit in the main filing space within the department. The old charts are filed alphabetically with claim numbers recorded. 1987-89 charts are in the department and some old charts (24 linear feet) are stored in a separate room. The filing space in the department is considered partly inadequate given the current chart retention practices, but can be resolved with mobile shelving. There is a need to establish a retention policy for charts.

Audits are performed upon request.

The physicians' dictation system consists of using dictation tape. The dictation system is old and tapes are not always clear, and staff cannot determine length of dictation on tape. Sometimes tapes are lost or misplaced.

The transcriptionists are using a combination of different word processors, which is inefficient. The following materials are transcribed:

- Discharge summaries
- Histories and physicals
- Psychology reports
- Discharge Planning reports every 5 weeks
- Progress notes
- Work assessments
- Pain control unit screening reports
- Miscellaneous and letters.

It is reported there is currently no backlog on reports.

6.14.2 Workload

Workload Indicator	Actual 1990	Actual 1991
Admissions	1,585	1,550

Estimated number of lines transcribed per week - 11,200 lines.

6.14.3 Staffing

Position	Budget FTE 1991	Projected FTE 1991
Supervisor	1.0	1.0
Stenographers	6.0	6.0
Total	**7.0**	**7.0**

Note that one person is working on Union business or is on WCB leave almost full time.

The allocation of work is reported as follows:

	FTE
Management/Library	1.0
Coding	2.0
Filing	0.2
Transcription	3.8
Total	**7.0**

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6.14.4 Worked Hours/Paid Hours

	1991
Total Paid Hours	12,740
Less Sick Hours	489 (65 days, or 9.3 days per person)
Paid Vac/Stat Hours	1,473
Paid WCB Hours	735 (105 days)
Paid Hours Worked	10,043

Comments

1. It is reported that keeping up with transcription workload is a problem. We observed the following:
   - the dictation equipment and quality is a problem
   - the staff work on different word processing systems
   - based on 800 lines per day per transcriptionist, the workload is 2.75 persons per week or 3.0 FTE per year. The balance of 0.8 FTE is the person on Union business and WCB leave.

6.14.5 Recommendations

1. *The total system of dictation and transcription should be examined in order to cost avoid adding staff. The productivity should be closer to 1,000 lines per day with the appropriate equipment.*

2. *Mobile filing system should be considered rather than microfilming. Microfilming can be expensive.*

3. *The proposed new computer system should reduce workload in health records.*

4. *When the above issues have been examined and implemented, then staffing needs should be reviewed.*

6.15 Physical Plant

6.15.1 Overview

The mission statement of the Physical Plant Department is to provide and maintain a safe and comfortable environment and to maintain the cosmetic appearance of the facility.

This department is responsible for the operation and on-going repair of the plant as well as the maintenance of the main hospital building, and associated grounds. In addition, it is called upon to maintain and provide services to the WCB building in Saint John.

The department is managed by a Supervisor who is assisted by an Engineer, three maintenance craftsmen and a gardener.

Currently, there is no full preventive maintenace system although the Supervisor is looking for a computerized planned maintenance system.

The plant appears well maintained and current staffing appears appropriate.

6.15.2 Workload

Workload Statistics

	1990	1991
Number of Work orders above daily routines	581	725

6.15.3 Staffing Data

Staffing

	Budget FTE	Actual FTE
Supervisor	1.0	1.0
Engineer	1.0	1.0
Maintenance Craftsman III (Carpenter)	1.0	1.0
Maintenance Craftsman II (Painter)	1.0	1.0
Maiantenance Craftsman I (Helper)	1.0	1.0
Gardener	1.0	1.0
Total	**6.0**	**6.0**

Statistical Information

	1990	1991	Budget
Total Paid Hours	11,570	10,920	10,920
Less:			
Paid Sick Hours	236	203	218
Paid Vac./Stat Hours	1,432	1,354	1,375
Paid W.C.B. Hours	146	70	55
Equals:			
Paid Hours Worked	9,755	9,292	9,272

Average sick days per person 5.2 days.

Comments

The staffing is appropriate for this size facility. Care must be taken that increasing workload at WCB building in Saint John does not compromise the work at the Centre.

6.15.4 Recommendations

1 *It is recommended that the department continue to examine the potential for a computerized preventive maintenance system, that can also be used for the WCB building in Saint John.*

2 *Staffing to remain the same.*

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Applied Manag

APPENDIX A

PROJECT STEERING COMMITTEE

MEMBERSHIP

Appendix A

Project Steering Committee

Mr. Brian Baxter, Executive Director, Corporate Services, Workers' Compensation Board

Mr. John Doucet, Executive Director, Client Services, Workers' Compensation Board, Chairperson

Mr. John Maguire, Assistant Administrator, Workers' Rehabilitation Centre and Project Coordinator

Dr. Gordon Mockler, Medical Director, Workers' Rehabilitation Centre

Ms. Dianne Ormandy, Administrator, Workers' Rehabilitation Centre

Mr. Andy Rauska, Director of Research, Workers' Compensation Board

Mr. John Roushorne, Chairman and Chief Executive Officer, Workers' Compensation Board

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APPENDIX B

LIST OF
PROJECT CONSULTANTS

Appendix B

Project Consultants

Dr. R. F. Fisher, Physiatrist in Chief, The Rehabilitation Centre, Ottawa

Mr. Stu Gourley, General Manager, Halifax Division, Applied Management Consultants, Halifax

Mr. Bryan Ferguson, Vice President, Strategic Planning and Information, Applied Management Consultants, Fredericton

Mr. Bob Kennedy, Senior Consultant, Applied Management Consultants, Fredericton

Dr. J. Michael Lacroix, President, Lacroix Rehabilitation and Psycho-Legal Services, Toronto

Mr. Alastair Lamont, Executive Vice President, Applied Management Consultants, Fredericton

Mrs. Donna Lordon, Associate Consultant, Applied Management Consultants, Fredericton

Mr. Glenn Monteith, Senior Consultant, Applied Management Consultants, Fredericton

Ms. Gaye Sydenham, President, Rehab Management International, Edmonton

Mr. Jim Wolstenholme, Vice President, Health Services Planning and Information, Applied Management Consultants, Fredericton

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Persons Consulted External to Workers' Rehabilitation Centre and Project Steering Committee

Saint John Regional Hospital
- J. Kent Tingley, Executive Director
- Dr. Louis Simon, Medical Director
- Dr. Phil Reid, Physical Medicine and Rehabilitation

Department of Health and Community Services
- Jim Carter, Assistant Deputy Minister, Institutional Services
- Bonny Hoyt- Hallett, Executive director, Planning and Evaluation
- Linda Jackson, Director, Program Support Services, Institutional Services
- Mike Flood, Senior Anglophone Hospital Liaison Officer
- Jean Castonguay, Senior Francophone Hospital Liaison Officer
- Brenda Boucher, Health Care Consultant-Rehabilitation, Public Health and Medical Services
- Nancy White, Research and Planning Officer, Planning and Evaluation

Forest Hill Rehabilitation Centre
- Margaret Randall, Executive Director
- Dr. Douglas Smith, Medical Director

Dr. Elliott Weiss, Physical Medicine and Rehabilitation, Moncton

Dr. Peter Johnson, Occupational Health and Safety, J.D. Irving Ltd.

Michel Poirier, Executive Director, NB Hospital Association

David Balmain, Executive Director, NB Medical Society

Gerry Cluney, Canadian Manufacturers Association

New Brunswick Federation of Labour
- Bill Whalen
- John Murphy

Chaleur Regional Hospital
- Lloyd Boudreau, Assistant Executive Director
- Francois Varin, Assistant Executive Director
- Sylvana Bosca, Health of Physiotherapy
- Pauline Marquis, Physiotherapist

Injured Workers' Associations
- Saint John - Murray Goodwin
- Saint John - Lydia Duguay
- Saint John - Bill Titus
- Edmundston - Laval Chenard

Campbellton - Richard Dubé

Elaine Goguen, Occupational Health Nurse, The Moncton Hospital

Sharon Steeves, Physiotherapist, Moncton

Peter Magee, Chiropractor, Saint John

Professor Ed Biden, Institute of Biomedical Engineering, UNB

Workers' Rehabilitation Services Outside of New Brunswick

Henry MacDonald, Executive Director, Client Services, Workers' Compensation Board of Ontario

Dr. Barb Wylie, Executive/Medical Director, Downsview Rehabilitation Centre, Ontario

John Wisoky, Executive Director, Association of Workers' Compensation Boards

Gordon Smith-Windsor, Executive Director, Wascana Rehabilitation Hospital, Saskatchewan

Ian Sinclair, Vice President, Operations, Workers' Compensation Board, Alberta

Workers' Compensation Board - New Brunswick

Beth O'Leary, Acting Director, Vocational Rehabilitation

Audrey Veall, Physical Assessment Committee, Manager

Applied Management Consultants

APPENDIX D

COSTS OF REHABILITATION SERVICES
FOR INJURED WORKERS

Appendix D

Rehabilitation Services Costs

for Injured Workers

1 *1991-1992 Workers' Rehabilitation Centre Service Chargebacks to Workers' Compensation Board*

Full day program (residential or commuter)	$160.00
Half day program	80.00
Appointments/visits	25.00

2 *1991-1992 Charges by Other New Brunswick Service Providers for Workers' Compensation Board Services*

Private Physiotherapy Clinics (per visit)	$ 27.50
Hospital visits (including Physiotherapy visits) (per visit)	55.00
Regional hospital per diem charges*	
Chaleur	461.00
Dr. Everett Chalmers	386.00
Moncton	402.00
St. John Regional	418.00

* Inpatient rehabilitation services are available only in regional hospitals.

3 Other Provinces

Wascana Injured Workers' Rehabilitation Program

Full day program (per day)	$178.00
Hostel stay (per day)	49.00
Total for residential program	227.00

Downsview Rehabilitation Centre

$500-800 per day for residential treatment, depending on the program.

APPENDIX E

COST COMPARISON OF
PROSTHETIC AND ORTHOTICS SERVICES

Prosthetic and Orthotic Cost Comparison

A cost comparison has been made utilizing as examples three services which WRC's Prosthetic and Orthotic Department (P&O) provides. P&O were asked to provide breakdowns of the time and materials that were consumed in providing the three services. Subsequently, private suppliers were asked to provide quotes for these same services.

The three patients which are referred to as "A", "B", and "C" required the following:

- Client "A" requires a Knee Brace;
- Client "B" requires a Below Knee Prosthesis; and
- Client "C" requires an Above Elbow Prosthesis.

Table 1 presents the costs of the three suppliers (P&O and two private companies).

Table 1 - Cost Comparison
WRC P&O Department and Private Suppliers

Supplier	Client "A" Cost	Client "B" Cost	Client "C" Cost	Total
WRC - P&O	$700	$2,385	$4,317	$7,402
Private A	$1,025	$3,030	$4,600	$8,655
Private B[1]	$910	$3,200	$4,000	$8,110

This table shows that for two of the three services under review the P&O costs are less than either of the two private suppliers. As well, the total cost to WCB of all three services is less at P&O than from either of the two private suppliers. The cost differential between private suppliers and P&O for the three patients under review

[1]Costs for this supplier were estimated by this company as the person currently responsible for costing and pricing services was on vacation.

is indicative of the savings experienced by having this function provided in the centre. In fact, if a cost analysis were performed for many of the common P&O services which require very little labor the results would be even more favorable. The reason this would be so is because P&O effectively eliminates the "middleman" who charges a markup in order to cover his or her own operating costs.

Contracting out only some of the services would reduce the overall productivity of the department's staff and increase the cost of providing its other services which are currently more cost effective. It is essential to consider the P&O services as a bundle of services, each of which contributes to the overall operational efficiency of the department. By removing some services the overall burden has to be borne by a smaller number of clients.

The overall conclusion is that the P&O department is a more cost effective approach for WCB to meet its clients' P&O needs than having these services supplied by private suppliers. Private suppliers must generate sufficient revenues to cover their operating costs, materials, supplies, taxes and yield a return on their investment. It is the absence of the last two items in particular that gives an advantage to WRC's P&O department.

The pages that follow provide a more detailed breakdown of how the costs for each patient were developed.

In determining the costs related to the provision of services to each client the following was performed:

- direct labor rates were calculated for each P&O staff member
- indirect departmental costs and a rate at which to allocate these costs to client projects were calculated
- indirect WRC costs and a rate of allocation were calculated.

These cost and rate calculations are presented next.

Direct Labor Rate Calculation

The direct labor rate for each staff member is calculated by dividing their salary and benefits (calculated as 15% of salary) by the number of hours available for work 1715 (assuming a 3 week vacation allowance).

Direct Labor Rates are as follows:

Certified Prosthetist/Orthotist	**$31.54**
Interning Prosthetist	**$23.02**
Prosthetic/Orthotic Technician	**$18.87**
Clerk/Typist	**$14.80**

Indirect Departmental Costs and Rate of Allocation

Indirect departmental costs include P&O staff time (and related wages and benefits) attributed to administrative and training activities, costs for education and dues, equipment, supplies and maintenance and repair.

Staff were asked to attribute their time to categories of activity. The following summarizes P&O staff results:

Staff Position	% of Time on Administration and Training
Certified Prosthetist/Orthotist	40%
Interning Prosthetist	20%
Prosthetic/Orthotic Technician	20%
Clerk/Typist	20%

The total cost of staff time spent on administration and training is $41,100. The balance of staff time was spent on direct work. This direct work is equivalent to 3 FTEs or 5145 hours.

Other departmental costs which includes education and dues, minor equipment, supplies and maintenance and repairs are budgetted for 1992 to be $8,452.

The allocation rate for indirect departmental costs was calculated on the following basis:

(P&O Staff Cost + other departmental costs) / total hours of direct work

In this situation:

($41,100+$8,452)/5145 = $9.63/hour of direct work

Therefore, indirect departmental costs are applied at a rate of $9.63 per hour of direct labor.

Indirect WRC Cost and Rate of Allocation

The indirect costs of the P&O department include the general services which support the department and the cost of the associated clients who stay at the facility specifically to be served by P&O.

General Services to support P&O include administration, housekeeping, health records, physical plant, transportation, depreciation and interest. In the 1990 financial statements these general services represented 43.3% of the total cost of operating WRC. P&O is estimated to require approximately 3.3% of these general service costs. This estimate is based on the following:

- P&O occupies 2,310 of the roughly 87,000 square feet (2.7%)
- P&O has a staff of 4, WRC has a total complement of 120 (1991 figure) (3.3%)
- P&O's 1992 budget is $161,000, WRC Therapeutic Services for 1992 will be approximately $3.7 million (4.3%)

In dollar terms, P&O will consume approximately $133,000 in general services in 1992.

Patient Services are consumed in addition to the utilization of general services. There are instances where clients are admitted over night or longer expressly for the services provided by P&O. These clients utilize many of the services of the centre which are estimated to cost $200 per patient day. (For P&O clients this is reduced by 4.3% to $192 to avoid double counting the cost of this department).

It is estimated, by P&O that on average each outpatient client spends one day as an inpatient (overnight). For 1992 it is projected that there will be 400 outpatients - and 400 overnight stays.

The cost of these patient services is therefore $76,800.

The allocation rate for indirect WRC costs was calculated on the following basis:

(General Service costs + Patient Service costs) / total hours of direct work

In this situation:

($133,000+$76,800)/5145 = $40.77/hour of direct work

Therefore, indirect WRC costs are applied at a rate of $40.77 per hour of direct labor.

Cost profiles for each client; "A", "B", and "C" are provided on the following pages.

Client A - 1 Generation II Knee Brace

Table A1 - Direct Labor Costs

Task	Hours By Staff Person				
	Certified Prosthetist/ Orthotist	Interning Prosthetist	Prosthetic/ Orthotic Technician	Clerk/ Typist	Total
•Appointment and Paperwork				.25	.25
•Assessment, Measuring and Casting	.75				.75
•Fitting of Orthosis	.75				.75
•Completion of Billing				.25	.25
•Shipping Brace			.25		.25
Total	1.5	0	.25	.5	2.25
Direct Labor Rate	31.54	23.02	18.87	14.80	
Direct Labor Charge	$47.31	$0.00	$4.72	$7.40	$59.43

Table A2 - Indirect or Allocated Costs

Indirect Cost Category	Per Hour Allocation Rate	Number of Hours	Total Allocation
Departmental Indirect Costs	$9.63	2.25	$113.40
WRC Indirect	$40.77		
Total Indirect	$50.40		

Material and Parts Costs

Generation II Knee Orthosis including stockinette and plaster bandage $527.77

Total Cost For Client A $700.60

Client B - 1 Below Knee Prosthesis

Table B1 - Direct Labor Costs

Task	Hours By Staff Person				
	Certified Prosthetist/ Orthotist	Interning Prosthetist	Prosthetic/ Orthotic Technician	Clerk/ Typist	Total
• Appointment and Paperwork				.25	.25
• Assessment, Casting, Evaluation, Ordering Parts, Pouring Cast	.25	2			2.25
• Cast Modification and Fabrication of Pet-G assessment socket		4			4
• Assessment of Check Socket, Alterations to Check Socket, Pouring of Definitive Mould		2			2
• Fabrication of limb, socket laminations, bench alignment, assembly of components and Initial fitting	.25	4			4.25
• Fitting of prosthesis including dynamic alignment and gait analysis	.25	3			3.25
• Completion of limb including shaping of foam cover, loctite of all components, final fitting and finishing of prosthesis	.25	3			3.25
• Completion of Billing			.5	.25	.25 .5
• Receiving Components, Checking order					
Total	1	18	.5	.5	20
Direct Labor Rate	31.54	23.02	18.87	14.80	
Direct Labor Charge	$31.54	$414.36	$9.44	$7.40	$462.74

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Table B2 - Indirect or Allocated Costs

Indirect Cost Category	Per Hour Allocation Rate	Number of Hours	Total Allocation
Departmental Indirect Costs	$9.63	20	$1008.00
WRC Indirect	$40.77		
Total Indirect	$50.40		

Materials and Parts Costs

Titanium components from Otto Bock	$ 393.45
Seattle Light Foot and spacer, 1 pair deep fit shoes and all materials to fabricate limb	$ 521.08
Total Cost Client "B"	$2,385.27

Client C - 1 Above Elbow Prosthesis

Table C1 - Direct Labor Costs

Task	Hours By Staff Person				
	Certified Prosthetist/ Orthotist	Interning Prosthetist	Prosthetic/ Orthotic Technician	Clerk/ Typist	Total
• Appointment and Paperwork				.25	.25
• Ordering Components	1	1			
• Cast, measurement and assessment	.25	.5			
• Cast poured and modifications made to cast		2			
• Vacuum formed Pet-G		1.5			
• Breaking out cast, Assessment of check socket	.25	2			
• Fabrication of Prosthesis (Inner socket, Wax, Outer Lamination)		4			
• Fitting of harness and cable control	.25	3.5			
• Finishing of prosthesis	.25	1.5			
• Final fitting and adjustments	.5	1.5			
• Completion of Billing				.25	
• Receiving Components, Checking order			.5		
Total	2.5	17.5	.5	.5	21.00
Direct Labor Rate	31.54	23.02	18.87	14.80	
Direct Labor Charge	$78.85	$402.85	$9.44	$7.40	$498.54

Table B - Indirect or Allocated Costs

Indirect Cost Category	Per Hour Allocation Rate	Number of Hours	Total Allocation
Departmental Indirect Costs	$9.63	21	$1058.40
WRC Indirect	$40.77		
Total Indirect	$50.40		

Materials and Parts Costs

Components purchased and materials from stock	$2,759.95
Total Cost Client "C"	$4,316.89

APPENDIX F

PHYSICAL ASSESSMENT
COMMITTEE STATISTICS

PHYSICAL ASSESSMENT COMMITTEE STATISTICS

YEAR	VOC REHAB REFERRALS	E.E.L. REFERRALS	MEDICAL SUPERVISION	RETURN TO WORK	OTHER (CLAIMS)	CANCELLED	TOTAL
1988	162(41%)	91(23%)	12(3%)	87(22%)	28(7%)	16(4%)	396
1989	227(48%)	90(19%)	24(5%)	109(23%)	-----	24(5%)	474
*1990	213(49%)	87(20%)	17(4%)	105(24%)	-----	13(3%)	435
1991	159(47%)	54(16%)	11(3%)	104(31%)	2(-%)	10(3%)	340

*Bathurst Office began seeing claimants at Physical Assessment Committee meetings

APPENDIX G

UTILIZATION OF THE
WORKERS' REHABILITATION CENTRE

Use of Workers' Rehabilitation Centre

Bathurst and New Brunswick

1986 - 1991

	1986	1987	1988	1989	1990	1991
WRC Total Admissions	1,976	2,132	2,301	2,299	2,294	2,374
Admissions by Counties Bathurst Regional Office						
Gloucester	232	212	231	191	180	84
Northumberland	110	117	145	146	120	91
Restigouche	138	111	121	158	112	57
Total	480	440	497	495	412	232
% of Total Admissions	24.3%	20.6%	21.6%	21.5%	18.0%	9.8%

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WORKERS REHABILITATION CENTRE
AD HOC OUT PATIENT APPOINTMENT UTILIZATION RATES BY COUNTY
1990 - 1991

County	Males	Females	Total	Working Age Pop.	Patient Rates
Albert	4	0	4	16,635	0.24
Carleton	16	0	16	17,600	0.91
Charlotte	32	2	34	16,760	1.91
Gloucester	20	0	20	58,185	0.34
Kent	15	3	18	20,380	0.74
Kings	143	41	184	36,615	3.91
Madawaska	21	5	26	24,375	0.86
Northumberland	11	0	11	34,265	0.32
Queens	14	6	20	8,060	1.74
Restigouche	7	2	9	26,680	0.26
Saint John	153	74	227	54,485	2.81
Sunbury	10	3	13	16,105	0.62
Victoria	7	7	14	13,635	0.51
Westmorland	53	4	57	74,545	0.71
York	61	2	63	52,265	1.17
N.B.	567	149	716	470,590	1.20

* Regular Out Patient cases are not included

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WORKERS REHABILITATION CENTRE
OUT PATIENT UTILIZATION RATES BY COUNTY
1990 - 1991

County	Males	Females	Total	Working Age Pop.	Patient Rates
Albert	2	0	2	16,635	0.12
Carleton	0	0	0	17,600	0.00
Charlotte	32	8	40	16,760	1.91
Gloucester	0	0	0	58,185	0.00
Kent	1	1	2	20,380	0.05
Kings	150	46	196	36,615	4.10
Madawaska	1	0	1	24,375	0.04
Northumberland	11	1	12	34,265	0.32
Queens	16	4	20	8,060	1.99
Restigouche	3	1	4	26,680	0.11
Saint John	267	77	344	54,485	4.90
Sunbury	14	4	18	16,105	0.87
Victoria	2	2	4	13,635	0.15
Westmorland	10	1	11	74,545	0.13
York	28	6	34	52,265	0.54
N.B.	537	151	688	470,590	1.14

* Ad Hoc Out Patient cases are not included

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WORKERS REHABILITATION CENTRE
TOTAL INPATIENT AND OUTPATIENT USE BY SEX AND COUNTY
1990 - 1991

	Inpatient Use				Outpatient Use				Total Use				Rates/1000				
	Males		Females		Males		Females		Males		Females		Males		Females		Total
County	Sep.	LOS	Sep.	LOS	Sep.	LOS	Sep.	LOS	Sepl.	LOS	Sep.	LOS	Sep.	LOS	Sep.	LOS	Sep. LOS
Albert	11	252	0	0	2	46	0	0	13	298	0	0	0.78	17.90	0.00	0.00	0.78 17.90
Carleton	34	704	11	262	0	0	0	0	34	704	11	262	1.93	40.00	0.63	14.89	2.56 54.89
Charlotte	15	342	13	360	32	730	10	277	47	1,072	23	637	2.80	63.94	1.37	38.00	4.18 101.94
Gloucester	42	1,201	7	157	0	0	0	0	42	1,201	7	157	0.72	20.64	0.12	2.70	0.84 23.34
Kent	39	878	5	119	1	23	4	95	40	901	9	214	1.96	44.19	0.44	10.51	2.40 54.70
Kings	17	380	9	363	150	3,353	87	3,509	167	3,733	96	3,872	4.56	101.95	2.62	105.75	7.18 207.70
Madawaska	65	1,195	14	251	1	18	5	90	66	1,213	19	341	2.71	49.78	0.78	13.98	3.49 63.75
Northumberland	61	1,519	9	244	11	274	1	27	72	1,793	10	271	2.10	52.33	0.29	7.91	2.39 60.24
Queens	26	686	7	62	16	422	10	89	42	1,108	17	151	5.21	137.49	2.11	18.68	7.32 156.17
Restigouche	34	790	12	532	3	70	3	83	37	860	15	415	1.39	32.22	0.56	15.55	1.95 47.78
Saint John	15	383	5	29	267	6,817	151	876	282	7,200	156	905	5.18	132.15	2.86	16.61	8.04 148.76
Sunbury	12	290	3	57	14	338	7	133	26	628	10	190	1.61	39.01	0.62	11.80	2.24 50.81
Victoria	31	536	5	317	2	35	9	571	33	571	14	888	2.42	41.85	1.03	65.10	3.45 106.94
Westmoreland	98	2,007	21	390	10	205	5	93	108	2,212	26	483	1.45	29.67	0.35	6.48	1.80 36.15
York	55	1,082	16	471	28	551	8	236	83	1,633	24	707	1.59	31.24	0.46	13.52	2.05 44.76
N.B.	555	12,765	137	3,414	537	11,848	300	7,476	1,092	24,093	437	10,890	2.32	51.20	0.93	23.14	3.25 74.34

* Out Patient LOS based on inpatient LOS

** Ad Hoc Out Patient Appointments are not included

WORKERS REHABILITATION CENTRE RATES
WRC VERSUS WCB RATES IN GENERAL HOSPITAL USE RATES
1990 - 1991

County	WRC ALL Sep Rate	WRC ALL P.D Rate	Gen. Hosp. Sep Rate	Gen. Hosp. P.D. Rate	Total Sep Rate	Total P.D. Rate
Albert	0.78	17.90	0.84	4.09	1.62	21.99
Carleton	2.56	54.89	3.47	18.35	6.02	73.24
Charlotte	4.18	101.94	1.01	6.38	5.19	108.32
Gloucester	0.84	23.34	2.03	9.85	2.87	33.19
Kent	2.40	54.70	0.98	3.04	3.39	57.74
Kings	7.18	207.70	1.31	8.19	8.49	215.89
Madawaska	3.49	63.75	1.93	8.94	5.42	72.70
Northumberland	2.39	60.24	2.16	9.08	4.55	69.31
Queens	7.32	156.17	5.21	21.09	12.53	177.26
Restigouche	1.95	47.78	2.32	13.01	4.27	60.78
Saint John	8.04	148.76	1.36	12.63	9.40	161.39
Sunbury	2.24	50.81	1.68	8.94	3.91	59.75
Victoria	3.45	106.94	2.35	9.39	5.79	116.33
Westmoreland	1.80	36.15	1.07	5.42	2.87	41.57
York	2.05	44.76	2.01	7.86	4.06	52.62
N.B.	3.25	74.34	1.74	9.04	4.99	83.38

* Out Patient LOS based on inpatient LOS for WRC
** General Hospital statistics are for 1988/89

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APPENDIX H

SUMMARY OF MEETING
WITH INJURED WORKERS

Summary of Meeting with Injured Workers

Introduction

Two consultants met with a group of injured workers receiving treatment at the Centre to obtain their perceptions on the Centre's role and operations. The group was a mix of resident and commuter clients. They were from around the province and over half were Francophone. A few had had more than one admission to the Centre.

A list of discussion issues had been sent to the members of the group in advance (attached), and they had taken the initiative to organize two meetings with other users of the Centre prior to their own meeting with the consultants. They brought the views of those meetings with them.

Findings

Most of the group members had received treatment for injuries through the public health system and/or private services. They described the services at the WRC as much more intensive and also more effective. However, they felt they participated very little in the planning of their treatment program and favoured greater involvement. Various persons were named as primary contact about the treatment plan and its implementation, but most commonly it was "therapist", either Occupational Therapist or Physiotherapist.

The greatest advantage of a WCB owned and operated WRC was seen to be the fact that this meant the Centre was interested in whether the worker was in fact rehabilitated and went back to work (much more than the public system or private services). Another advantage was that this meant bilingual services, as WCB had a commitment to bilingualism. This was perceived as a considerable strength of the Centre. The disadvantage, which was not necessarily due to WCB ownership, was the distance involved for many. Group members expressed regret the Centre was not in the middle of the province.

At the meeting, group members expressed reservations about the idea of integration with public health system users, concerned that they would no longer have priority. In the sheets handed in from their own meetings, most respondents indicated integration was a good idea, and some gave reasons. Usually these were that it might be easier to budget (more cost efficient) and that these services were needed for others. Again however, concern was expressed regarding the priority of injured workers.

Regarding responsibility for themselves outside the hours of treatment, all views were unanimous that injured workers should have complete responsibility for themselves (but that they should take their treatment seriously). Resident workers did not mind signing in and out of the Centre (considered it useful in case of fire!) but objected to the 2300 hour curfew. They did not seem to mind it so much that they felt negative towards the Centre as a whole. They did not like the idea of finding their own accommodation in the vicinity, because of inconvenience and because they found living with other injured workers provided emotional and social support. The latter advantage was especially important to the women.

Suggested changes in WRC operations, for which there was general support, were:

- More information/orientation prior to or immediately at admission
- Greater use of the Patient (resident) Committee for orientation and programming, and possibly monitoring of gym after hours
- Designation of a particular therapist in each discipline, to provide continuity, and designation of one team member or person as contact person
- Earlier admission to the Centre after injury

- "Listening" to patients
- Provision of medical specialists at the Centre
- Discharges on Fridays instead of Mondays
- Changing or abandoning the curfew
- Availability of the pool and gym after hours

Some group members also suggested having the therapeutic program continue over weekends. They felt they would be in and out faster.

APPENDIX I

REPORTS OF
DR. RON FISHER

THE REHABILITATION CENTRE
LE CENTRE DE RÉADAPTATION

A division of the Royal Ottawa Health Care Group Une division des services de sante Royal Ottawa

REÇU / RECEIVED
25 -03- 1992

March 19, 1992.

Ms. Donna Lordon,
Associate Consultant,
Applied Management Consultants,
512 George Street,
Fredericton, New Brunswick.
E3B 1K1

Dear Donna:

RE: ROLE STUDY AND OPERATIONAL REVIEW,
WORKERS' REHAB CENTRE, NEW BRUNSWICK

Further to our conversation, I have received the document entitled Draft Summary of Workshop Findings for the Workers' Compensation Board. I think it was extremely well presented and certainly brought out the major discussion areas and recommendations to be presented concerning the Rehab Centre.

As concerns the specific questions you had asked and including the workload of the physicians, I feel that there is adequate staffing at the present time for the workload involved at the Centre. I think the staff would be quite adequate for them to move to a program basis and within that structure begin the process of developing all the associated structures such as research, education, quality assurance, etc. Depending on the number and types of programs established, there may be one or two physicians within each program and I would suggest one of the physicians be appointed as director of the program.

As concerns the issue of continuing education, I feel that this can only be very clearly documented and planned for once the various programs are established. It would then be up to the physicians as well as other members of the team to target their continuing education to the needs of that specific program versus the need of the specific physician or team member. Obviously with the population served by the Workers' Rehab Centre there would likely be a fair amount of overlap on such issues such as pain management, soft tissue injuries, etc. and again this would be perfectly clear once the types of programs and the goals and directions are established. There may be some specialized areas within the Centre where you would want to appoint one physician to develop that expertise such as quality assurance, risk management or CQI. This person could then be used as a resource for the other physicians and their programs.

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The same might hold for areas such as research and specific skill acquisition.

Concerning the issue of special support, there may be a requirement for some input particularly from people used to working in a program environment to help with the establishment of the programs themselves once patient data is available. Following this, for the clinical needs of the various programs, I would expect specific contacts to be arranged for each program depending on their individual needs. This may require an orthopedic surgeon for one program and a neurologist or neurosurgeon for a different program. It certainly would be nice to have a liaison developed with a physiatrist to help with some of the more difficult and complex cases. Again, this is a rather difficult issue to try and sort out at the present time but I think would be much clearer once programs have been established and their specific patient populations defined.

I trust these comments are useful for your needs. If I can be of any further assistance, please do not hesitate to contact me. I certainly did enjoy working with you and the other consultants and hope that some day we again can share some time and expertise on such a project.

Sincerely,

F.R. Fisher, MD, FRCPC,
Physiatrist-in-Chief.

FRF/nb

ROLE STUDY & OPERATION REVIEW
WORKERS' REHAB CENTRE

EXPENSES: MARCH 5 & 6, 1992

1) Phone consultations: Jan. 13/92; Jan. 20/92, Feb. 24/92; March 4/92		$ 100.00
2) Document Review & Report Preparation		350.00
3) On-Site Visit March 5 & 6, 1992		2,000.00
4) Expenses, On-Site Visit (receipts attached)		841.91
- parking	- $ 25.00	
- taxi	- 20.00	
- hotel & meals	- 242.65	
- airfare	- 554.26	
TOTAL:		$3,291.91

Dr. F.R. Fisher,
Physiatrist-in-Chief.

ROLE STUDY AND OPERATIONAL REVIEW OF
WORKERS' REHABILITATION CENTRE
March 5 & 6, 1992

Following the interviews and discussions held at the Workers' Rehab Centre, it is my opinion that the first decision to be made on the future of this Institution and the direction of care for the injured worker in the Province of New Brunswick, is for the Workers' Compensation Board to determine the role of the Workers' Rehab Centre. The basic decision is whether the Workers' Compensation Board wishes to remain in the treatment area or to turn the facility to a civilian run organization. There is no doubt, following the various discussions, that the feelings of the staff and patients is that the Centre must remain with the Workers' Compensation Board. The second decision to be made by the Board then is to provide the autonomy of the Workers' Rehab Centre. The Workers' Rehabilitation Centre must establish its own Board for deciding policy and direction. They must also have autonomy around financial, human and physical resources. Once this is determined, then Mission Statements can be written for the Centre and roles and objectives established which would fit into the Mission Statement.

Recommendation #1: That the Workers' Rehab Centre continue in its present role with a primary mission to the injured workers. Because of its specialty operation, it is felt that it would be most appropriate for the Workers' Rehab Centre to maintain the option for future delivery of specialized services to civilian population or organizations.

Recommendation #2: As it is felt that the Workers' Rehab Centre should maintain a specialized role in the treatment of the injured workers, there is a need to develop a role in a number of areas. The first area is that of specific assessments. The Workers' Rehab Centre should become the specialty area for assessment of injured workers and in order to do this in an appropriate time and manner, there should be direct linkages developed with the clinical care givers at the Bathurst Unit as well as other units in the Province of New Brunswick. This linkage should allow the direct admission of the injured worker from his home treatment area to the Rehab Centre. In the area of specialized treatment, it is recommended that the Workers' Rehab Centre continues to develop special programs with the needs of the injured worker in mind. The Centre has a tremendous opportunity to develop a research base and disseminate knowledge about the care of the injured worker. This same issue stands for education, both internal and external, to the Rehab Centre.

Recommendation #3: The Workers' Rehab Centre should work towards attaining accreditation as soon as possible.

Recommendation #4: It felt there is a great opportunity to improve the efficiency and effectiveness of the treatment services at the Rehab Centre by organizing these services into programs which would identify dedicated teams of individuals to serve these specific needs of groups of patients. First of all the Centre would need to carefully assess and document the types of patients and difficulties presently being treated and then decide on the specific programs that would direct treatment to these various groups of injured workers. The teams should be large

enough that staff might be able to rotate through various teams in the Centre and yet specific enough in their mandate to become experts in the field. In the long run this will be a natural way to focus treatment, develop expertise, develop efficiency and the base required for ongoing research and education. This process has already started with the development of the Pain Care Unit, the Back Care Program and Work Hardening Program. Other possibilities to develop in the future would be an assessment program, a low back soft injury program and many others depending on the need.

Recommendation #5: It is critical to the future services at the Rehab Centre that vocational expertise be established within the Centre as soon as possible to work with all programs. Linkage between the vocational worker and the client should take place as soon as possible following admission and linkage should be established again as soon as possible with the Workers' home unit. The issue of possibly having a claims person on site should also be investigated. This in the long run should dramatically improve the time factors in making decisions regarding the patients' future role in the work environment.

Following a review of the specific areas, further recommendations are made concerning the areas. The first to be discussed is that of the pain control unit. This is an excellent basic program. The program does require additional resources particularly in psychology for research and for vocational issues. Because of the educational value of this unit and the types of patients and clients served at the Rehab Centre, it is felt that there should be a link with this program to other programs in the Centre looking at the philosophy of their approach to pain and the education of the injured worker about pain. It is recommended that the Pain Control Unit also establishes linkages with other pain units of a similar nature in the country. There is a great possibility for this unit to develop the expertise so that in the future they may be able to package and "sell" their services to the civilian population. Again there is tremendous research potential in this unit.

Recommendation #6: The Pain Control Unit should continue and be enhanced. The unit should define their role as a program within the Workers' Rehab Centre. ~~There could perhaps be a review of~~ the roles of the team members particularly around the nursing component and establish whether a nurse could be involved more in counselling and direct patient contact. The role in research needs to be developed.

Following interviews with a number of clients with the Workers' Rehab Centre, both inpatients and outpatients, there was no doubt that the injured worker sees the Rehab Centre as their own treatment centre and generally are very happy with the services. Many of the issues which were discussed appear to be fairly minor problems mainly secondary to difficulties in communication.

Recommendation #7: The Workers' Rehabilitation Centre should continue with the mandate for treatment of the injured workers under the auspices of the Workers' Compensation Board. There should be an improvement in patient orientation with the provision of an information booklet which I understand is under production as well as issues such as tours, specific staff assignment, etc. It may be appropriate to appoint one team member

as a "case manager" within the Rehab Centre. The issue of nursing providing this role should be explored. There should be a review with the staff and the clients around the issues of responsibility. Such issues as wearing an identification wrist bracelet, the curfew, attendance at treatment programs, etc., must all be reviewed and it is recommended that these become the responsibility of the individual treatment program versus the responsibility of the Rehab Centre itself.

Following review of the Prosthetics and Orthotics Department, it is felt that the present staffing level is adequate and the physical plant is in good condition. The staff do have an expertise in upper extremity injuries. There were no major problems or issues outstanding at the present time as concerns the internal operation.

Recommendation #8: The Prosthetics and Orthotics Department of the Workers' Rehab Centre should continue with its present mandate and role. It would certainly improve efficiency to have a computerized system of inventory control. The issue of services being supplied to civilians should be explored but likely would only be a viable alternative if there were long waiting lists for civilian service providers. The P & O department may also, at some point, be able to offer their specialized expertise to the civilian population. There is presently an excellent working relationship with the civilian organizations and these should not be jeopardized. The patient information system needs to be improved to [illegible] outside agencies. WCB should establish standards for outside manufacturers including the need for certified prosthetists and orthotists and work to be done by accredited facilities.

Following interviews with the medical staff of the Workers' Rehab Centre, there were a number of issues which were obviously creating some difficulties within the staff. There was noted to be difficulties hiring bilingual staff and this is certainly not unique to this Centre or to New Brunswick. There was a strong feeling of interference by the Board in the treatment decisions and recommendations provided by the physicians. It was noted there was great difficulty in obtaining specialist appointments. It was felt that the budget approval process was very long and complicated with no local control. There was felt to be fairly difficult relationships with the head office. There was a major concern around orientation of new staff as to WCB rules and regulations. There was felt to be poor communication with the Board. There was felt to be inadequate information provided on the patients on their referral to the Workers' Rehab Centre.

Recommendation #9: The medical staff should take a lead in organizing and establishing a program structure in the Workers' Rehab Centre. The medical staff should work with administration to develop the autonomy of the Workers' Rehab Centre which would include enhanced budget controls, improved access to the Rehab Centre on a timely basis and the development of correct linkages with the Bathurst Unit and other outside treatment units. The medical staff should develop a formal and direct communication with the Board as an example establishing regular meetings with the various medical staff at the Rehab Centre. Issues of control and decision making need to be further explored. It is felt that once

the programs are established there would then be a much easier method of determining access to specialist care and perhaps the development of combined clinics, contract services, etc., could then be explored. The medical staff should initiate a review and update and formalize an orientation process for new staff which likely would include a significant amount of time spent at Workers' Compensation Board headquarters. The medical staff should take a lead role with administration in obtaining accreditation. The medical staff should take a lead role in the establishment and promotion of research and education at the Rehab Centre. In order to successfully enter the area of research, the Rehab Centre would have to hire and dedicate a full time staff member as a research coordinator. This individual would then be responsible not only for research activities but also the development and encouragement of research amongst the various programs and departments. The medical staff must develop QA indicators and once the programs have been established, explore issues of CQI (Continuous Quality Improvement). The medical staff in concert with the appropriate individuals should review the role of recreology. It is recommended that this service move to become a much more therapeutic role and a member of the treatment team. Similarly, the medical staff should be involved in a review of the role of nursing. The nurse needs to become a pivotal member of each team and develop and utilize expertise for issues such as counselling. The medical staff should also review the issue of "self medication" which would seem to be most appropriate for the clientele being serviced.

The review of the Workers' Rehabilitation Centre was most enjoyable, showing the dedication of the existing staff and their expertise in treating the injured worker. Although many other provinces and Workers' Compensation Boards have taken a different direction, it is felt that because of the geography and the types of clients serviced, that the Workers' Rehabilitation Centre should maintain its primary mandate for treatment of the injured worker. It should continue to develop specialized expertise which will allow it to become a leader in the treatment of the injured worker in this country. It is felt that the recommendations contained herein should likely be priorized with a development program over the next 18 to 24 months. At the end of that time it is likely the staff will be very comfortable in their new roles and the beginning of projects in research and education as well as accreditation could be obtainable goals.

F.R. Fisher, MD, FRCPC,
Physiatrist-in-Chief.
March 9, 1992.

APPENDIX J

REPORT OF
DR. MICHAEL LACROIX

J. MICHAEL LACROIX CONSULTANTS

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REHABILITATION AND PSYCHO-LEGAL SERVICES

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Anne Mississauga, M.A.

REÇU / RECEIVED
16 -03- 1992

March 7, 1992

Ms. Donna Lordon
Applied Management Consultants
151 Brunswick St.
Fredericton, New Brunswick
E3B 1G7
Fax: (506) 452-7883

Dear Ms. Lordon:

RE: REF. 40-1589; OPERATIONAL REVIEW AND ROLE STUDY OF NEW BRUNSWICK WORKERS' REHABILITATION CENTRE (WRC)

At your request, I conducted a review of the Psychology services provided at the WRC, both as part of the Psychology Department and in the context of the Pain Control Unit. You had also asked me to consider WCB services in a larger perspective and comment on broader psychological issues relating to workers' rehabilitation, drawing on my observations at the WRC, and my background and knowledge of rehabilitation issues and workers' compensation services more generally. My evaluation included a review of file material which you kindly provided, an on-site evaluation, as well as discussions with various WRC senior personnel and other consultants. Let me begin with my review of Psychology services, and I will then address the broader issues.

A. PSYCHOLOGY SERVICES

Present Role

The Psychology Department at WRC is a consulting service. It comprises 2 licensed psychologists and 2 psychometrists (psychological assistants who administer and score tests). Two of the four are fully bilingual, and another is functionally bilingual. They see approximately 600 clients per year, or about 30% of the WRC population. These are usually seen at the request of the treating physician, although all clients in the Pain Control Unit are seen by Psychology, and there are periodic referrals from case workers. All clients seen by Psychology undergo some form of assessment. About 2/3 of these assessments are psychovocational in focus and evaluate aptitudes, interests and personality features with a view to

making recommendations as to alternative vocational options. About 1/3 of these assessments are clinical personality assessments to diagnose the possible presence of significant psychological problems arising from the injury and its sequelae, such as post-traumatic stress disorder, anxiety, or depression. Only about 1% are neuropsychological assessments, which is low in a rehabilitation context generally, but understandable in that WRC has no head injury clinic. About 25% of the clients who are assessed in Psychology go on to receive counselling or psychotherapy, for an average of about 6-8 sessions; if necessary, these clients are then referred to a clinical psychologist in the community for continued treatment following their discharge from WRC.

In addition, Psychology is intimately involved with the Pain Control Unit, providing both personality and psychovocational assessments on all clients, as well as group therapy (about 6 sessions per week). The group therapy sessions focus on issues such as pain behaviour, financial concerns, medications, anger management, coping skills, and employment counselling.

Workload statistics are maintained by the Department, and C.Q.I. is provided by sending evaluation questionnaires to referring sources and injured worker clients on a monthly basis, with a report on these being forwarded to the management committee every three months. Scientific research has not been part of the department's activities since the mid-80's. Staff development activities have been mostly in-house, with the exception of a couple of outside courses, of peripheral relevance.

Evaluation

In terms of the actual amount of work done (number of assessments, etc), the Psychology Department is carrying more than is typical for institutional settings. When one factors in the administrative requirements (e.g. meetings, etc), it is difficult to see how the Department can do all of its clinical work within a 35 hour work week. Moreover, the quality of the work appears to meet the usual standards. The tests employed are entirely appropriate for the client population. The Department's Policy and Procedures Manual is pertinent and up-to-date. For the purpose of this evaluation, I reviewed a sample of files containing client assessments, and the quality of the work easily matches that of psychological assessments in other institutional settings. I also reviewed data pertaining to the timeliness of psychological intervention, and here also the Psychology staff appears to be doing a superb job, in some cases actually seeing a client on the same day that the referral reached the Department; in the normative case, clients are seen in less than a week, and the report is sent within a week after evaluation. Furthermore, a review of C.Q.I. questionnaire summaries indicated that both referral sources and injured workers were very happy with the service provided. Discussion with the Manager of Psychology as to the nature of therapeutic intervention strategies for both individual and group therapy revealed that these are fully in keeping with the literature and with what is done elsewhere. I am particularly supportive of the attempt to discuss financial issues within the group therapy format in the Pain Control Unit as, in my experience, these issues are invariably a primary source of stress for these clients.

In sum, the Psychology Department appears to be doing an excellent job in the clinical work that it provides. This is a particularly important conclusion in the context of the availability of psychological services in New Brunswick generally.Prior to this evaluation I reviewed the list of psychologists who meet the requirements of the Canadian Register of Health Service Providers in Psychology; this includes psychologists who are licensed in the province and

who have met the further criteria of specialization in clinical or health Psychology related areas. Only 22 psychologists in the entire province appear to be competent to be able to provide clinical services of some kind to WCB injured workers. However, very few of these can claim some specific expertise in rehabilitation , and almost all work for other hospitals. The inescapable conclusion is that the WRC is the centre of expertise for Rehabilitation Psychology in New Brunswick. Without WRC, injured workers simply could not get adequate services through the private sector at present.

Recommendations

Notwithstanding the Department's excellent clinical services, a number of suggestions may be considered to improve services still further.

1. Within WRC, it takes 3 to 4 weeks for physicians to identify patients likely to require psychological assessment and intervention. Earlier identification of clients with likely psychotraumatic components would be both more effective therapeutically and more cost-effective.

2. The role of the Psychology Department needs better definition. Because of the demands on Psychology's strained resources, there is some conflict between the needs for psychological assessments (including psychovocational assessments) and the needs for therapeutic intervention. A clearer sense of mission for WRC would optimize Psychology's contributions.

3. The department is understaffed. I understand that a staff member was lost a couple of years ago, who was never replaced. As it is, the Department is overworked by the standards of similar institutions. If the client population were to increase (e.g. by admitting Medicare patients), or if the Department were to better fulfill some of the other functions that it should fulfill (see point 4), it would be stressed beyond the breaking point.

4. Scientific research should become part of the Department's mission. Not only do psychologists have expertise in research methodology by virtue of their training, but the client population at WRC begs for scientific investigations, and WRC is in a unique position to carry out such research (which would also provide considerable visibility). Psychology should become involved in its own scientific investigations and, in addition, it could serve as a resource of methodological and statistical expertise for research carried out by other departments at WRC. This would require some increase in staff.

5. To enhance C.Q.I., some formal mechanism of peer review or file audit should be implemented. This could be done using departmental staff if the Department should grow in size, or psychologists from sister institutions across the country could provide a yearly audit of randomly selected files.

6. Good though the Department may be, it cannot continue to maintain its skills for long without continuing education. An institutional commitment to staff education through conferences and courses is imperative, even if these are offered outside of New Brunswick. Moreover, sponsored programmes of study should be compatible with the mission statements for WRC and its Psychology Department.

B. More General Recommendations

As you had asked for my comments on broader aspects of WCB rehabilitation service delivery, may I offer the following.

1. WRC should become duly accredited, as befits the nature of the institution. This would also provide a mechanism for continued attention to quality improvement.

2. WRC should continue to serve WCB clients exclusively. It is difficult to see where those clients would go if WRC were to take on a more general mission with Medicare clients, particularly given the dearth of rehabilitation services in New Brunswick.

3. WRC should operate autonomously from WCB head office. The Ontario experience has shown that it is impossible to operate properly a rehabilitation facility when it is closely governed by a bureaucracy with a much broader mission.

4. WRC's mission needs to be better defined. At present there is considerable confusion as to the types of clients that WRC should serve. This confusion permeates throughout the institution (see point A. 2 above). A clearer sense of mission should then be matched by a clearer statement of goals and objectives.

5. WRC should move toward a team approach, with each team having a particular clinical entity as its focus (e.g. head injury; long term back problems; hand clinic). The model here is the Pain Control Clinic. This would foster the development of recognized expertise in the relevant areas. From this basis, WRC might later consider moving toward a program management service delivery system.

6. Research should become an integral part of WRC's mission. As I indicated above, it is <u>the</u> centre for Rehabilitation Psychology in New Brunswick, and this clearly also applies to other WRC departments. By virtue of its intimate link to WCB clients, it is in a unique position to make significant contributions to the field of rehabilitation, and also to enhance both its own visibility and that of the New Brunswick WCB.

7. WRC should again develop an educational role, particularly as pertains to family physicians. GPs are the gatekeepers of the health delivery system. Providing them with the kind of knowledge that is taken for granted at WRC should facilitate client rehabilitation and cut costs.

8. Rehabilitation should be started much earlier. In most cases, the system does not begin to focus on alternative job options until 18-24 months post-injury. This is much too late, as by then the vicious circle of factors that lead to chronicity are well ingrained, and very resistant to change.

9 Rehabilitation should become integrated with other WCB services. The model here again is the Pain Control Unit, where psychovocational assessments are carried out as an essential part of the service, so that the injured worker has a goal to strive for.

I trust the above will be to your satisfaction. Feel free to call if you need additional information or if I may otherwise be of assistance.

Yours sincerely,

J. Michael Lacroix, Ph.D., C.Psych., A.R.W.